Vermont Center for Resiliency, PLLC
Clinician Name, Degree, License
Office Practice Location Address
Clinician Name, Degree, License
(802) xxx-xxxx

PROGRESS NOTE (Blueprint / Vermont Center for Resiliency, PLLC)

Patient Name: _____ DOB: _____ Date of Session _____

Session # _____ Start time:_____ am / pm Stop Time_____ am / pm CPT code_____ add on Code_____
Location of session: Office or Telehealth (_Video / Audio-only) and Initial if confirmed secure location in state this writer is licensed to practice in and local crisis resource reviewed _____ HIPAA Compliant Telehealth Platform _____Client Call back #_____
Session Focus:
Objective / Symptoms:
Evidence-Based Practices, Therapy Modalities & Interventions used in session:
Assessment (client response to treatment & progress):
Plan:
Next Session Scheduled:
Diagnosis:
Any referrals or service coordination follow up:
Any safety needs, risk or planning identified?
Any other notes above session today or care plan updates:

Clinician Signature: _____ Clinician Name, Degree, Licensure Date	Clinician will review care plan in Supervision: Supervisor: Name, Degree, Licensure

Patient Name _____ DOB _____ DOS _____