COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL
PROGRESS NOTES (SIRP FORMAT)

PROGRESS NOTE TYPE			
1. Date: _____ 2. Start time: _____ End time: _____ 3. Please select the note type: ☐ Individual ☐ Group – answer fields 3a and 3b: 3a. ____ Number of Counselors 3b. ____ Number of Patients			
PATIENT INFORMATION			
4. Name (Last, First, and Middle):	5. Date of Birth (mm/dd/yyyy):		6. Medi-Cal or MHLA Number:
7. Address:			
8. Gender:	9. Preferred Language:	10. Race/Ethnicity:	11. Phone Number: Okay to Leave a Message? ☐ Yes ☐ No
PROVIDER AGENCY			
12. Name:	13. Contact Person:		14. Phone Number:
15. Address:	16. Fax:		17. Email:

SIRP FORMAT	
18. S - Situation The patient presenting situation at the beginning of intervention. May include counselor/clinician observations, the patient subjective report and the intervention setting.	
I – Intervention Provider methods used to address the patient statements, the provider observations, and the treatment goals and objectives.	

R - Response The patient response to intervention and progress made toward individual plan goals and objectives	
P - Plan The treatment plan moving forward, based on the clinical information acquired and the assessment.	

19. If the patient's preferred language is not English, were linguistically appropriate services provided?

Yes ☐ No ☐ If no, please explain:

20. Provider Name:	21. Signature:	22. Date:
23. Additional Provider Name if applicable:	24. Signature:	25. Date:

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

EXTERNAL SAPC REVIEW *This section will include communication between SAPC and the agency/provider.*

Comments:

Assigned Staff:_____ Reviewed by: _____ Signature: _____ Date: _____

INTERNAL SAPC USE ONLY *This section is reserved for internal SAPC use only.*
Comments: Assigned Staff:_____ Reviewed by: _____ Signature: _____ Date: _____

PROGRESS NOTE INSTRUCTIONS

PROGRESS NOTE TYPE

1. Please enter the date
2. Please enter the start and end time
3. Please select the type of progress note. If a group note is selected, the number of counselors present in the group and the number of patients in the group are required.

PATIENT INFORMATION

4. Enter the patient name in the order of last name, first name, and middle name.
5. Enter the patient date of birth.
6. Enter the patient Medi-Cal or My Health LA (MHLA) number. If the number is not known, leave the space blank.
7. Enter the patient address.
8. Enter the patient gender
9. Enter the patient preferred language
10. Enter the patient race/ethnicity
11. Enter the patient phone number. Check box to indicate if it is okay to leave a message at this phone number.

PROVIDER AGENCY

12. Enter the agency name
13. Enter the contact person
14. Enter the phone number
15. Enter the address
16. Enter the fax
17. Enter the email

NOTE-SIRP FORMAT

18. Enter the progress note information for the individual in the SIRP format
19. Enter any linguistically appropriate services if the patient preferred language is not English
20. Enter the provider name
21. Enter the provider signature
22. Enter the date
23. Enter an additional provider name such as a supervisor, or a second provider present during the encounter.
24. Enter the additional provider signature
25. Enter date

EXTERNAL SAPC REVIEW

This section will include communication between SAPC and the agency/provider

INTERNAL SAPC USE ONLY

This section is reserved for internal SAPC use only.

SUBMIT THIS FORM TO:

Fax: (323)-725-2045
Phone: (626)-299-4193

FOR ADDITIONAL SAPC DOCUMENTATION PLEASE SEE
http://publichealth.lacounty.gov/sapc/NetworkProviders.htm