CONTRA COSTA
HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

WRAP Progress Note/ Billing Form

Mansa Gibe

NAME / MRN

Service Date: 2-15-17 **RU:** _____
Staff #: _____ **Hours*** 01 **Mins** 00 **# in Group:** _____
Co-Staff #: _____ **Hours*** _____ **Mins** _____ **Total Travel Time: Hours** 00 **Mins** 03

*** Service duration must include travel time, if applicable**

Services: (Check one)

☐ 300 No Show	☒ 313 Evaluation	☐ 351 Group Therapy	☐ 561 Case Mgmt – Linkage
☐ 400 Client Cancel	☐ 315 Plan Develpmt	☐ 355 Group Rehab	☐ 564 ICC
☐ 700 Staff Cancel	☐ 317 Rehab	☐ 357 Group Collateral	☐ 571 Case Mgmt - Plan Develpmt
☐ 371 Crisis Int.	☐ 331 Assessment	☐ 358 IHBS	☐ 540 Non-Billable Services
☐ 311 Collateral	☐ 341 Indiv Therapy	☐ 541 Case Mgmt - Placement	☐ 580 Non-Billable - Lock-outs

Location of Services: (Check one)

☐ **1** Office	☐ **5** School	☐ **11** Faith-based	☐ **15** Licensed Care Fac. (Adult)	☐ **19** Residential Tx Center (Child)
☐ **2** Field	☐ **8** Correctional Facility	☐ **12** Healthcare	☐ **16** Mobile Service	
☐ **3** Phone	☐ **9** Inpatient	☐ **13** Age-Specific Center	☐ **17** Non-Traditional Location	☐ **20** Telehealth
☒ **4** Home	☐ **10** Homeless/Shelter	☐ **14** Client's Job-site	☐ **18** Other	☐ **21** Unknown

Service Strategies: (Check up to three, if applicable)

☐ **50** Peer/Family Services	☐ **53** Supportive Education	☐ **56** With Social Services	☐ **59** With Develpmt Disabled
☐ **51** Psycho-Education	☐ **54** With Law Enforcement	☐ **57** With Substance Abuse	☐ **60** Ethnic-specific Services
☐ **52** Family Support	☒ **55** With Health Care	☐ **58** With Aging Providers	☐ **61** Age-specific Services
			☐ **99** Unknown

Is the client pregnant? ☐ **Yes** ☒ **No** **(If yes, please document how service was pregnancy-related)**

☐ **Interpreter** **Name of Interpreter:** _____
Language service provided in other than English: ☐ **Spanish** ☐ **Other** _____

Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

1a. Treatment goal(s) addressed, if appropriate.

Treatment goal is to ward off evil spirits (request by daughter and patient) and give herbs for the patient. The herbs will be helpful for

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1b. Description of Current Situation/Reason for Contact: (Status update, needs, clinical impressions) **DSM-5 Code** _____ **ICD-10 Code** _____

Daughter started notice that her mother started to repeatedly ask questions; memories would be lost, misplaced items, and forgetting what daily items are called. Thought it was a result of bewitching. This is not a cause of bewitching because the patient is in her 60s.

Herbal medicines will be given.

Memory loss due to aging, this is a natural cause.

2. Focus of Activity: (Intervention and Response to Intervention, what did you do? What is the consumer's response?)

Alzheimer's is at one of the early stages; Mansa seems to be misplacing items, forgetting converstation, seems jumble her words, and has trouble remembering people (like she doesn't seem to remember har grand kids).

Give herbs to protect memory (to slower the rate of the memory loss). The medicine will be made of ginger, honey, avocado seeds, papaya seeds, lemons, and aloe vera. This solution should be taken before her meal (could be any meal of the day).

Patient wants protection for her mind and body (from evil spirits). This wil be done through the necklace that she will be given.

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3. Plan (e.g. Coordination of Care, Referrals, Follow-up) *Specify what the consumer/family/providers are to do.*

Check in once every two weeks, I will travel to their house. Patient should have someone watching her all the time. She should wear her necklace at all times. The necklace will be a coin with special properties to protect her form bewitching. She should also take her medicine daily.

Signature/License/Job Title	Printed Name	Date
Babu	Babu	2-15-17

Co-Signature/License (if applicable)	Date

Data Entry Clerk Initials _____