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| --- | --- | --- | --- | --- | --- | --- |
| **This report is a(n):** |  | **Initial Treatment Plan** |  | **Treatment Plan Update** |  | **Discharge Summary** |
| **Modality:** |  | **Individual** |  | **Conjoint/Family** | | |

**ATTENDANCE**

|  |  |  |
| --- | --- | --- |
| Date of Initial Session: Click or tap to enter a date. | Last Date Attended: Click or tap to enter a date. | Total Number of  Sessions Attended: |
| Date of Absences: | Reasons for Absences: | |
| Service Delivery Type: Telehealth  In-Person | Service delivery type has been assessed and continues to be clinically appropriate: Yes  No | |

**I received and reviewed the following records provided by the PSW or Optum (required prior to the intake assessment):**

|  |
| --- |
| CFWB Background Records (e.g. case plan and pertinent court reports) |
| Copies of available prior psychological/psychiatric evaluations and treatment plans |
| CFWBRelease of Information |
| **OR** |
| I have not received CFWB background records. Date records requested from PSW: Click or tap to enter a date. |

**ASSESSMENT OF RISK FACTORS**

Risk assessment should be ongoing and include all risk factors documented on the 04-176A and known to the provider. Risk factors that will be a focus of treatment must be documented in the clinical progress sections below. Please refer to Clinical Risk Documentation guidance in [TERM Treatment Plan Documentation Resources](https://www.optumsandiego.com/content/dam/san-diego/documents/term/manuals/term-provider-handbook-appendices/TERM%20Treatment%20Plan%20Documentation%20Resources.pdf).

|  |  |  |
| --- | --- | --- |
| **Dates of Assessment:** Click or tap to enter a date. | | |
| Suicidal ideation | History of harm to others/attempt | Distress, disability, or dysfunction in:  Social/Relational  Occupational  Other important activities |
| Suicidal plan | History of trauma or abuse |
| Suicidal intent | Reasonable probability of significant deterioration in an important area of life functioning |
| History of self-harm/attempt |
| Homicidal ideation |

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| --- | --- | --- |
| Homicidal plan | Reasonable probability of not progressing developmentally as appropriate |  |
| Homicidal intent |
| Substance abuse |

**CLIENT SYMPTOM CHECKLIST**

|  |  |  |
| --- | --- | --- |
| The following *current* symptoms were reported and/or observed: | | |
| Angry mood  Anhedonia  Anxious mood  Appetite concerns  Avoidance  Concentration challenges  Denial  Depressive mood  Derealization  Distorted blame  Distressing dreams | Euphoric mood  Euthymic mood  Exaggerated startle response  Fatalistic cognitions  Fatigue  Fear of being alone  Flashbacks  Grandiose cognitions  Hallucinations  Helplessness  Hopelessness | Hypervigilance  Intrusive memories  Irritable mood  Isolation  Memory challenges  Physiological reactions to trauma reminders  Psychomotor agitation  Sleep disturbance  Somatic complaints  Other: |

**TREATMENT PROGRESS**

|  |
| --- |
| **INSTRUCTIONS:** It is essential that therapists working with CFWB parents accept the true finding of the Juvenile Court as a fact of the case. If CFWB offers the family Voluntary Services instead of filing a petition with the Court to take jurisdiction, a true finding does not apply; however, the therapist is expected to accept the allegations of abuse as facts of the case.  Identify the applicable focus of treatment area from the drop-down menu. Document progress since last treatment report. Progress should include information pertaining to evidence-informed interventions utilized and client’s response to the clinical interventions (i.e., changes in the client’s attitudes, beliefs, and behaviors as reported by parent, SW, and behavior observations of parent in sessions). Documentation of progress reflects therapist’s clinical assessment of progress rather than client’s direct statements or quotes. For each update, please include new progress in applicable section and do not delete previous entries. Please note when a treatment area is no longer an active focus of clinical attention.  Add/delete rows as needed. |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **FOCUS OF TREATMENT:** Choose an item.   |  |  | | --- | --- | | **Initial Assessment:** |  | | **First Update:** |  | | **Second Update:** |  | | **Third Update:** |  | | **Fourth Update:** |  | |
| **FOCUS OF TREATMENT:** Choose an item.   |  |  | | --- | --- | | **Initial Assessment:** |  | | **First Update:** |  | | **Second Update:** |  | | **Third Update:** |  | | **Fourth Update:** |  | |
| **FOCUS OF TREATMENT:** Choose an item.   |  |  | | --- | --- | | **Initial Assessment:** |  | | **First Update:** |  | | **Second Update:** |  | | **Third Update:** |  | | **Fourth Update:** |  | |

**DISCHARGE SUMMARY**

|  |  |
| --- | --- |
| Date of Discharge: Click or tap to enter a date. | Date SW Notified: Click or tap to enter a date. |
| Reason for Discharge:  Successful completion/met goals  Poor attendance  Office of Child Safety Case Closed   Other (specify): | |

**PARENT SIGNATURE**

|  |
| --- |
| I have discussed this treatment plan with my provider.  Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **For telehealth services:** Please review the treatment plan with the client and document the date.  Date reviewed: Click or tap to enter a date. |

**DIAGNOSIS**

List your diagnostic impressions of the parent. Record as many coexisting mental disorders, general medical conditions, and other factors as are relevant to the care and treatment of the individual. All diagnoses identified on the CFWB referral should be included as endorsed, rule out, or criteria not met. If diagnosis was made by previous provider and is being maintained by history, state so.

The Primary Diagnosis should be listed first

|  |  |
| --- | --- |
| **ICD-10 Code** | **DSM-5-TR Diagnosis** |
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**ADDITIONAL COMMENTS**

Any recommendations offered are within the scope of provider’s role as a TERM provider and the clinical rationale is clearly stated.

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**PROVIDER SIGNATURE**

|  |  |
| --- | --- |
| Provider Printed Name: | License/Registration type and #: |
| Signature: | Signature Date: Click or tap to enter a date. |
| Provider Phone Number: | |

**REQUIRED FOR INTERNS ONLY**

|  |  |
| --- | --- |
| Supervisor Printed Name: | Supervisor Signature: |
| License type and #: | Date: Click or tap to enter a date. |

Submit Initial Treatment Plan/Update as per the authorized reporting schedule to Optum TERM at Fax: 1(877) 624-8376. Optum TERM will conduct a quality review and will be responsible for forwarding approved Quarterly Progress Reports to the Protective Services Worker.

**For Medi-Cal funding:** Authorization for continued services is dependent on Medical Necessity review of the treatment plan. Providers will be notified of determination within fourteen (14) business days of treatment plan submission.