|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 or treatment plans  |
| **[ ]** Copy of the latest CANS  |
| [ ]   Consent to Treat (04-24P or 04-24C) |
| **[ ]** 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[ ]  Academic[ ]  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 |

|  |  |  |
| --- | --- | --- |
| [ ]  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:** |
| [ ]  Abusive to animals (not better explained by sensory seeking behaviors)[ ]  Aggression[ ]  Anger[ ]  Arguing[ ]  Appetite concerns[ ]  Attention span concerns[ ]  Bullying[ ]  Concentration challenges[ ]  Crying easily[ ]  Destroying property[ ]  Developmentally inappropriate sexual behaviors[ ]  Disinhibited attachment[ ]  Dissociative behaviors[ ]  Inappropriate defiance | [ ]  Eager to please[ ]  Eloping behaviors[ ]  Excessive sensory seeking behaviors[ ]  Fatigue[ ]  Fire setting[ ]  Gastrointestinal concerns[ ]  Hyperactivity[ ]  Hypertonia[ ]  Hypervigilance[ ]  Hypotonia[ ]  Irritability[ ]  Lonely[ ]  Lying[ ]  Nightmares | [ ]  Screaming[ ]  Self-esteem problems[ ]  Separation anxiety[ ]  Shyness[ ]  Sleep problems[ ]  Somatic complaints[ ]  Stealing[ ]  Stimming behaviors[ ]  Stubborn[ ]  Temper tantrums[ ]  Unexplained fear[ ]  Withdrawn[ ]  Worry[ ]  Social isolation[ ]  Other:        |

**TREATMENT PROGRESS**

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| **INSTRUCTIONS:** 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 caregiver, SW, collateral contacts and behavior observations of client 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:** |       |

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**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):       |

**TREATMENT PLAN REVIEW**

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| **[ ]** I have reviewed this plan with the youth in an age/developmentally appropriate manner. Date of review: Click or tap to enter a date. |

**DIAGNOSIS**

List your diagnostic impressions of the child/youth. 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** |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |

**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:       | Provider Fax 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.