**This report is a(n):  Initial Treatment Plan  Treatment Plan Update  Discharge Summary**

**If Initial Treatment Plan, due date to Optum TERM (6 weeks from Therapy Referral mailing date) is:**

|  |  |  |  |
| --- | --- | --- | --- |
| Provider: |  | Phone: | Fax#: |
| SW Name: |  | SW Phone: | SW Fax: |
| **ATTENDANCE** | | | |
| Date of Initial Session: | | Last Date Attended: | Number of  Sessions Attended: |
| Date of Absences: | | Reasons for Absences: | |

**SPECIFIC TREATMENT PLAN**

**Plan should address Protective Issues listed on Therapy Referral form. *Add/delete rows as needed.***

|  |  |
| --- | --- |
| **PROTECTIVE/TREATMENT ISSUES as Related to Risk Factors and Measurable Goals**  **(e.g., measurable means of observing progress)** | **Target Date or**  **Met Date** |
| **Goal/Indicator:**  **Measure/Behavior:**  **Progress:**  **Method:** |  |
| **Goal/Indicator:**  **Measure/Behavior:**  **Progress:**  **Method:** |  |
| **Goal/Indicator:**  **Measure/Behavior:**  **Progress:**  **Method:** |  |
| **Goal/Indicator:**  **Measure/Behavior:**  **Progress:**  **Method:** |  |
| **Goal/Indicator:**  **Measure/Behavior:**  **Progress:**  **Method:** |  |
| **Goal/Indicator:**  **Measure/Behavior:**  **Progress:**  **Method:** |  |

**DISCHARGE SUMMARY**

|  |  |
| --- | --- |
| Date of Discharge: | Date SW Notified: |
| Reason for Discharge:  Successful completion/met goals  Poor attendance  CWS Case Closed    Other (specify): | |

**DIAGNOSIS**

List the appropriate diagnoses. Record as many coexisting mental disorders, general medical conditions, and other factors as are relevant to the care and treatment of the individual.

The Primary Diagnosis should be listed first

|  |  |  |  |
| --- | --- | --- | --- |
| **ID (ICD-10)** | **Description** | **Corresponding DSM-IV TR Diagnostic Code or V Code** | **Corresponding DSM-IV-TR Diagnostic Description or V Code Description** |
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**Comments** (Include Rule Outs, reasons for diagnostic changes, and any other significant information):

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|  |

**CLIENT SIGNATURE**

I have discussed this  Initial Treatment Plan  Treatment Plan Update  Discharge Summary with my provider.

**Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**

|  |  |
| --- | --- |
| **PROVIDER SIGNATURE:** | |
| Provider Printed Name: | License/Registration #: |
| Signature: | Signature Date: |
| Provider Phone Number: | Provider Fax Number: |
| ***Required for Interns Only*** | |
| Supervisor Printed Name: | License type and #: |
| Supervisor Signaure: | 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 CWS SW.  Date faxed to Optum TERM: |