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| Person’s Name (First MI Last):       | Record #:       | Date of Admission:       |
| Organization/Program Name:       | DOB:       | **Gender:** [ ]  Male [ ]  Female [ ]  Transgender |
| **SECTION I: Reason for Update – This section may be completed by an unlicensed provider.** |
| [ ]  Annual Update [ ]  Re-Admission [ ]  Interim Update of New Information**Date of Most Recent** **Comprehensive** **Assessment:**       |
| Child/Adolescent Comprehensive Assessment Section(s) for UpdateCheck the box(es) next to the section(s) of the assessment which you are updating. Be sure to label all additional/updated information in your narrative with the heading of the section of the Assessment being updated |
| [ ]  Presenting Concerns | [ ]  Addictive Behavior and Substance Use History |
| [ ]  Custody  | [ ]  Mental Health and Addiction Treatment History |
| [ ]  Living Situation | [ ]  Medical and Physical Health Summary |
| [ ]  Family | [ ]  Mental Status Exam |
| [ ]  Developmental Information | [ ]  Diagnosis |
| [ ]  Cultural and Religious Considerations | [ ]  Person Served Strengths/Abilities/Resiliency |
| [ ]  Employment | [ ]  Social Support and Functioning |
| [ ]  Caregiver Resources and Needs | [ ]  Education |
| [ ]  Legal Involvement/Legal Status History | [ ]  Risk |
| [ ]  Trauma History | [ ]  Activities of Daily Living |
| [ ]  Other: | [ ]  Other: |
| **Update Narrative:** List each assessment section being updated with narrative explanation below it. |
|   |
| **Signature/Credentials** (If Licensed Clinician did not obtain the information above): [ ]  No Signature Required  | **Date:** |

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| **SECTION II: Diagnosis Change – This section must be completed by a qualified provider** |
| **Diagnosis: :** [ ]  No Change [ ]  If Changed Complete Below **[ ]**  DSM-IV Codes **[ ]**  DSM 5 Codes [ ]  ICD-9 Codes [ ]  ICD-10 Codes |
| **Check Primary/Billing Diagnosis**  | **Code** | **Narrative Description**  |
| [ ]  |  |  |
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| **Person’s Name (First / MI / Last):**  | **Record #:** |
| Child /Family/Guardian Expression of Service Preferences |
| Service Preferences:       |

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| **Prioritized Assessed Needs:** [ ]  No Additional Recommendations Clinically IndicatedAC-Active, PD-Person Declined, F/G-Family/Guardian declined, DF-Deferred, RE-Referred Out (If person or family/guardian declined/deferred/referred out, please provide rationale) |
|  | **AC** | **PD\*** | **F/G\*** | **DF\*** | **RE\*** |
| **1.**  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **2.**  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **3.**  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **4.**  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **\*Child or Family/Guardian Declined/Deferred/Referred Out Rationale(s) (Explain why Child or Family/Guardian Declined to work on Need Area; List rationale(s) for why Need Area(s) is/are Deferred/Referred Out below).**[ ]  None**1.**      **2.**      **3.**       |

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| **Further Evaluations Needed:**  |
|  [ ]  None Indicated | [ ]  Psychiatric[ ]  Visual | [ ]  Psychological[ ]  Auditory | [ ]  Neurological[ ]  Nutritional | [ ]  Medical [ ]  Educational[ ]  SU Assessment | [ ]  Vocational [ ]  Other: |

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| **Was Outcomes tool administered?** [ ]  Yes [ ]  No If Yes, specify: |
| **Level of Care Indicated Services Recommendation:** [ ]  No change **/**  |
| **Child Family Guardian Response To Recommendations:** [ ]  Not Applicable /  |
| For Annual or Interim Updates |
| **Change In IAP Required**: [ ]  No [ ]  Yes (If Yes, complete the IAP Revision/Review Form to record needed changes in Goal(s), Objective(s), Interventions, Services, Frequency, and/or Provider type) |

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| **Person’s Name (First / MI / Last):** | **Record #:** |

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| **Person’s Signature** (Optional, if clinically appropriate) | **Date:** | **Parent/Guardian Signature** (If appropriate): | **Date:** |
| **Clinician/Provider - Print Name/Credential:** | **Date:** | **Supervisor - Print Name/Credential** (if needed): | **Date:** |
| **Clinician/Provider Signature:** | **Date:** | **Supervisor Signature** (if needed): | **Date:** |
| **Psychiatrist/MD/DO** (If required): | **Date:** | **Next Appointment:****Date:** **-** **Time** [ ]  **am** [ ]  **pm** |

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| Date of Service | Provider Number | Loc. Code | Prcdr. Code | Mod 1 | Mod2 | Mod3 | Mod4 | Start Time | Stop Time | Total Time | Diagnostic Code |
|       |       |       |       |     |     |     |     |       |       |       |       |