|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 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 Update Check 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:** |

|  |  |  |
| --- | --- | --- |
| **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** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| **Person’s Name (First / MI / Last):** | **Record #:** |
| Child /Family/Guardian Expression of Service Preferences | |
| Service Preferences: | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Prioritized Assessed Needs:**  No Additional Recommendations Clinically Indicated  AC-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.** | | | | | |

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

|  |
| --- |
| **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) |

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

|  |  |  |  |
| --- | --- | --- | --- |
| **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** | |

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