Organization Name:	**Program Name:**	
Individual's Name (First / MI / Last):	**Record #:**	**DOB**:

Type of Scheduled Contact: ☐ In-Person Meeting: ☐ Onsite / ☐ Offsite – Location: ☐ Telephone

Service *(check ONE service only)*	**Purpose** *(check purpose(s) for the indicated service)*
☐ Case Consultation ☐ Family Consultation ☐ Collateral Contact ☐ Complex Care Coordination ☐ Other:	☐ Assessment of the appropriateness of current services ☐ Coordination/Planning ☐ Discharge/Transition/Aftercare planning ☐ Clinical consultation ☐ Other**:**

	Name:	**Agency/Relationship to person served:**
List of Participants		

Summary of discussion with this contact (for ex: IAP goals/objectives/ interventions, critical event or condition descriptor):

Actions that will occur as a result of this contact	**Responsible Party:**
1.	**1.**
2.	**2.**
3.	**3.**
4.	**4.**

Completed By - Print Staff Name/Credentials:	**Staff Signature:**	Date:
Supervisor - Print Name/Credentials (if applicable**):**	**Supervisor Signature:**	Date:
Individual's Signature (Optional):		Date:

Date of Service	Staff Identifier	Loc. Code	Service Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Duration in Minutes