







Organization Name:						Program Name:				
Individual's Name (First / MI / Last):							Record #: DOB:			
Type of Program:  □ CSU □ Respite Bed □ Overnight Substance Use Program □ Overnight Child/Adolescent Program □ Intensive Outpatient – Discrete Service Delivered □ Individual (= or > 25 min.) □ Group (= or > 60 min.) □ Outpatient Rehabilitation □ Other:										
☐ Shift Note: ☐1st Shift (Day) ☐ 2nd Shift ☐ 3rd Shift (Night) ☐ Daily Note										
New Issues / Stressors / Extraordinary Events Presented Today: ☐ New Issue Resolved, No Update Required ☐ New Issue, CA/IAP Update Required ☐ None Reported Explanation:										
Goal(s)/Objective(s) Addressed As Per Individualized Action Plan:										
Goal _ Objective _ Objective _		_ Objec		jective _ jective _		Objec Objec		Objective	Objective Objective	Goal Objective Objective
Functioning (observed or reported):										
Intervention(s) / Method(s) Provided (For IOP - Include how services addressed early recovery issues):										
Response to Intervention and Progress toward Goals and Objectives:										
Plan / Additional Information:										
Completed By - Print Staff Name/Credentials:  Date:										
Completed By - Print Staff Name/Credentials: Staff							Staff Signature:			
Supervisor - Print Name/Credentials (if applicable):  Supervisor Signature:									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
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