MENTAL HEALTH PROVIDER PROGRESS REPORT

☐ NEW ☐ ON GOING

CONSUMER INFORMATION		TODAY'S DATE:
Name:		DOB:
Consumer First Seen:	Sessions to date:	
Number of authorized visits completed: (i.e. 5 out of 8)		
PROVIDER INFORMATION		
Provider Name:		Phone #
Referral Source:		
Reason for Referral:		
CLINICAL DIAGNOSIS		
Presenting Problem:		
Axis I:	Axis II:	
Axis III:		
Axis IV:		
Axis V:		
All Current Medications		Prescribed By
Describe Intervention Utilized and Treatment Goals		
Describe Consumer's and/or Family's Response to Intervention as Relative to Treatment Goals		
Describe/Discuss Barriers to getting treatment (if any)		

Additional Treatment needed? Yes ☐ No ☐
If Yes, Discuss Recommendations and Rationale for Additional Treatment
Discuss Fade Out Plan (include how many sessions are needed to meet goals)
Provider Signature:

Please return completed report to:

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Name of Service Coordinator

- ☐ 525 2nd Street Suite 300, Eureka, CA 95501
- ☐ 1116 Airport Park Blvd., Ukiah, CA 95482
- ☐ 180 3rd Street, Lakeport, CA 95453
- ☐ 1301-A Northcrest Drive, Crescent City, CA 95531