

## Follow-Up Summary

CLIENT NAME: \_\_\_\_\_

CASE #: \_\_\_\_\_

**STATUS OF PROGRESS:**

**Target Problem(s)**

- Deteriorated
- No change
- Minimal improvement
- Moderate improvement
- Significant improvement
- Not addressed/ Plan changed
- Unknown \_\_\_\_\_

**REASON CASE CLOSED:**

- Goals met/ Client satisfied
- Client dropped out against advice
- Client referred
- Other: \_\_\_\_\_

**REFERRALS: (check all that apply)**

**Client referred to:**

- Substance abuse treatment
- Mental health treatment
- Other: \_\_\_\_\_
- No referral

**Level of care:**

- Community Resources
- Outpatient
- Intensive outpatient
- Partial hospitalization
- Inpatient
- Other: \_\_\_\_\_

**Provider/Facility/Resource (name, address, phone):**

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<b>SOU SIGNED</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>AUTHORIZATION TO RELEASE INFORMATION SIGNED (AUD)</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>SATISFACTION QUESTIONNAIRE GIVEN</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**CLINICAL FOLLOW-UP:**

Routine follow-up with client, family members, and other providers for continuity of care and to review need for additional services. ***Follow-up with the client must be attempted at least one (1) time within two (2) to four (4) weeks after last session***

Date of follow-up/attempt: \_\_\_\_\_

Date of follow-up/attempt: \_\_\_\_\_

Did client receive services for which they were referred?  yes  no  unknown

**Summary / Comments:** \_\_\_\_\_

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