Magellan HEALTHCARE®

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):

_____

SOU SIGNED	☐ **YES**	☐ **NO**
AUTHORIZATION TO RELEASE INFORMATION SIGNED (AUD)	☐ **YES**	☐ **NO**
SATISFACTION QUESTIONNAIRE GIVEN	☐ **YES**	☐ **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: _____

_____

