Client Name: _____ Client Number: _____ DOB: _____

I. Presenting Problem: (who requested service & what precipitated referral)

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II. Evaluation: (brief demographic statement, observation of current behavior, client's report of precipitating events, Hx of SA,SI, Psych IP/OP and Past Diagnosis, Hx of Substance Abuse, Legal Hx – violent acts, WATCH RESULT, supports/strengths/resources, information from collateral contacts)

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Less Restrictive Attempts: _____

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Collateral Contact Information: _____

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III. Clinical Impressions: (interpretation of all available information, including all known risk and protective factors, reasons LR options are not appropriate)

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IV. Action Plan: (intervention regarding identified risks, referrals, disposition [with whom, when], follow-up)

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_____ _____ _____

Clinician Signature/Degree/Specialty/ID Printed Name Date

Client Name: _____ Client Number: _____ DOB: _____

ADDITIONAL NARRATIVE INFORMATION:

Clinician Signature/Degree/Specialty/ID | Printed Name | Date