CDR Case Management Form

Name of CDR Provider: ____________________
Phone Number: ____________________
Tax ID Number: ____________________ Assessment Coordinator Name: (please print) ____________________

Client Last Name: ____________________ First Name: ____________________ Date of Birth: ____________________

Address: ____________________

Case Open Date: ____________________ Detox Related? ☐YES ☐NO Detox Extension Granted H0049 ☐YES ☐NO
Date of First Appt. Offered ____________________ Detox Extension Date: ____________________

Section A – Diagnostic Assessment Interview

Date of First Interview: ______ Did Client Show? ☐YES ☐NO Date of 2nd Interview: ________Did Client Show? ☐YES ☐NO
Location of 1st interview H0001: ____________________ ☐Telephonic H0001

Location of 2nd interview H0002: ____________________ ☐ 2nd Telephonic H0002

Outcome of Assessment **(please check √ one)**
☐Reimbursable SA intervention accepted ☐Adjustment counseling referral ☐Closed **(Complete Section D)**

Section B

Mid-Treatment Review: ☐**YES** ☐**NO**
Closing Date ________

Date of Phone Review H0047: ____________________
Or
Date of Face-to-Face Interview H0022: ____________________

Section C

Discharge Planning: ☐Yes ☐No Closing Date: ________

Date of Phone Review H0050: ____________________
or
Date of Face-to-Face Interview H0006: ____________________

Section D – Closing Reasons and/or Outcomes

Diagnostic Assessment (please check √ one)

☐ Client did not show or uncooperative, assessment completed

☐ Client did not accept recommendations

☐ Referral to Community Resource Type: ________

☐ Referral to mental health provider:

Name: ____________________

Mid-treatment Review (please check √ one)

☐ Client withdrew from service against CDR/medical advice

☐ Provider discharged client early, client did not cooperate

☐ Client needs more restrictive treatment

☐ Provider discharged client early, treatment satisfactory

☐ Other: ____________________

Adjustment Counseling (please check √ one)

☐ Client did not show or uncooperative, assessment not completed

☐ Client did not accept recommendations

☐ Referral to Community Resource Type: ________

☐ Referral to mental health or substance abuse provider

☐ Counseling completed no further treatment

☐ Case Reopened, additional sessions provided

Name: ____________________

Discharge Planning (please check √ one)

☐ Client withdrew from service against CDR/medical advice

☐ Provider discharged client early, client did not cooperate

☐ Client needs more restrictive treatment

☐ Provider discharged client early, treatment satisfactory

☐ Discharge planning process completed

☐ Other: ____________________

Section E – Adjustment Counseling H0025

First Session Date : ________ Second Session Date: ________ Third Session Date: ________ Number of Total Sessions________
Diagnosis Code :____________________
Medication: ☐Yes ☐No If yes, list: ____________________
Problem Description: **(please check √ at least one)**

☐S/A ☐Physical ☐Vocational/Occupational ☐Financial ☐Legal ☐Emotional/Personal ☐Family/Marital

☐Other (please describe) ____________________

Risk Assessment Checked:
Risk or harm to self? ☐YES ☐NO Risk or harm to others? ☐YES ☐NO Risk or harm from others? ☐YES ☐NO

Section F – Work/Family Representative or EAP Representative Referrals

Did the above representative refer the client? ☐**YES** ☐**NO** Was referral made to the above representative? ☐**YES** ☐**NO**
Name: ____________________

Section G – Authorization Signature

Did client sign authorization consent form? ☐YES ☐NO Date:

Please fax completed forms to: ValueOptions at 248.697.0908

CDR FORM 06/29/10