

Client Name

Client EqualityCare ID #

CLINICAL: Current information / Signs & symptoms: What are the signs and symptoms that the patient is currently exhibiting & progress toward goals? **Please include clinical for each of the following area of treatment: Individual Therapy, Group Therapy, Unit Milieu (including interactions with staff/ peers), School, and Therapeutic Passes.** Justification for continued treatment:

Family therapy (include specific issues currently being addressed):

Medications (dosages & frequency; for Psych PRN meds, specify reason and how often used, include any meds started or discontinued with dates and reason for change):

- | | |
|----|-----|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

Patient specific treatment plan w/goals (include: level of observation, interventions, frequency of interventions)

Discharge Plan (Include providers)

Estimated length of stay:

Fax form to APS Healthcare toll-free @ 1- 888- 245-1928

Forms can be found on-line at www.wyoming.apshealthcare.com