

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? <input type="checkbox"/> YES <input type="checkbox"/> NO
Date of First Appt. Offered _____	Detox Extension Granted H0049 <input type="checkbox"/> YES <input type="checkbox"/> NO Detox Extension Date: _____

Section A – Diagnostic Assessment Interview	
Date of First Interview: _____	Did Client Show? <input type="checkbox"/> YES <input type="checkbox"/> NO
Location of 1 st interview H0001: _____	Date of 2 nd Interview: _____ Did Client Show? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Telephonic H0001
Location of 2 nd interview H0002: _____	<input type="checkbox"/> 2 nd Telephonic H0002
Outcome of Assessment (please check <input checked="" type="checkbox"/> one)	
<input type="checkbox"/> Reimbursable SA intervention accepted <input type="checkbox"/> Adjustment counseling referral <input type="checkbox"/> Closed (Complete Section D)	

Section B	Section C
Mid-Treatment Review: <input type="checkbox"/> YES <input type="checkbox"/> NO	Discharge Planning: <input type="checkbox"/> Yes <input type="checkbox"/> No Closing Date: _____
Closing Date _____	
Date of Phone Review H0047: _____	Date of Phone Review H0050: _____
Or	or
Date of Face-to-Face Interview H0022: _____	Date of Face-to-Face Interview H0006: _____

Section D – Closing Reasons and/or Outcomes	
Diagnostic Assessment (please check <input checked="" type="checkbox"/> one)	Adjustment Counseling (please check <input checked="" type="checkbox"/> one)
<input type="checkbox"/> Client did not show or uncooperative, assessment completed	<input type="checkbox"/> Client did not show or uncooperative, assessment not completed
<input type="checkbox"/> Client did not accept recommendations	<input type="checkbox"/> Client did not accept recommendations
<input type="checkbox"/> Referral to Community Resource Type: _____	<input type="checkbox"/> Referral to Community Resource Type: _____
<input type="checkbox"/> Referral to mental health provider:	<input type="checkbox"/> Referral to mental health or substance abuse provider
Name: _____	<input type="checkbox"/> Counseling completed no further treatment
	<input type="checkbox"/> Case Reopened, additional sessions provided
	Name: _____
Mid-treatment Review (please check <input checked="" type="checkbox"/> one)	Discharge Planning (please check <input checked="" type="checkbox"/> one)
<input type="checkbox"/> Client withdrew from service against CDR/medical advice	<input type="checkbox"/> Client withdrew from service against CDR/medical advice
<input type="checkbox"/> Provider discharged client early, client did not cooperate	<input type="checkbox"/> Provider discharged client early, client did not cooperate
<input type="checkbox"/> Client needs more restrictive treatment	<input type="checkbox"/> Client needs more restrictive treatment
<input type="checkbox"/> Provider discharged client early, treatment satisfactory	<input type="checkbox"/> Provider discharged client early, treatment satisfactory
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Discharge planning process completed
	<input type="checkbox"/> Other: _____

Section E – Adjustment Counseling H0025	
First Session Date : _____	Second Session Date: _____ Third Session Date: _____
Diagnosis Code : _____	Number of Total Sessions _____
Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list: _____
Problem Description: (please check <input checked="" type="checkbox"/> at least one)	
<input type="checkbox"/> S/A	<input type="checkbox"/> Physical
<input type="checkbox"/> Vocational/Occupational	<input type="checkbox"/> Financial
<input type="checkbox"/> Legal	<input type="checkbox"/> Emotional/Personal
<input type="checkbox"/> Family/Marital	
<input type="checkbox"/> Other (please describe) _____	
Risk Assessment Checked:	
Risk or harm to self? <input type="checkbox"/> YES <input type="checkbox"/> NO	Risk or harm to others? <input type="checkbox"/> YES <input type="checkbox"/> NO
	Risk or harm from others? <input type="checkbox"/> YES <input type="checkbox"/> NO

Section F – Work/Family Representative or EAP Representative Referrals	
Did the above representative refer the client? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Was referral made to the above representative? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Name: _____	

Section G – Authorization Signature	
Did client sign authorization consent form? <input type="checkbox"/> YES <input type="checkbox"/> NO	Date: _____