From Open Door Community Health Centers

SPECIALITY MENTAL TRACKING SHEET

Patient's Name:_____ DOB:_____ MR#_____

Referral Date:_____ Diagnosis:_____ PCP:_____

Treatment Goal: 1._____ 2._____ 3._____

Treatment goal assessment of functioning is rated from 1-5 as following:

1=low 2=moderately low 3=moderate 4=moderately high 5=high

	Date of Visit	Assessment of Functioning
1		1 2 3 4 5 notes:
2		1 2 3 4 5 notes:
3		1 2 3 4 5 notes:
4		1 2 3 4 5 notes:
5		1 2 3 4 5 notes:
6		1 2 3 4 5 notes:
7		1 2 3 4 5 notes:
8		1 2 3 4 5 notes:
9		1 2 3 4 5 notes:
10		1 2 3 4 5 notes:
11		1 2 3 4 5 notes:
12		1 2 3 4 5 notes:
PCP Approval Required For continued Visits		**❑ Approval Obtained**
13		1 2 3 4 5 notes:
14		1 2 3 4 5 notes:
15		1 2 3 4 5 notes:
16		1 2 3 4 5 notes:
17		1 2 3 4 5 notes:
18		1 2 3 4 5 notes:
19		1 2 3 4 5 notes:
20		1 2 3 4 5 notes:
21		1 2 3 4 5 notes:
22		1 2 3 4 5 notes:
23		1 2 3 4 5 notes:
24		1 2 3 4 5 notes: