(Due to Optum TERM within 12 weeks from Intake Assessment and every 12 weeks until discharge)

**Check one:** [ ]  **Update** [ ]  **Discharge Summary**

|  |  |  |  |
| --- | --- | --- | --- |
| Facilitator: |       | Phone:       | Agency:       |
| SW Name: |       | SW Phone:       | SW Fax:       |
| **ATTENDANCE** |
| Date of Initial Group Session: Click or tap to enter a date. | Last Date Attended: Click or tap to enter a date. | Number of Sessions Attended:       |
| Date of Absences:       | Reasons for Absences:       |
| Service Delivery Type: Telehealth [ ]  In-Person [ ]  | Service delivery type has been assessed and continues to be clinically appropriate: Yes [ ]  No [ ]   |
| **Rating Scale For Documenting Group Participation, Homework, And Treatment Progress**:**0** = N/A: not addressed yet or not applicable to parent's case**1** = Rarely **2** = Not often **3** = Sometimes **4** = Often **5** = Very often; routinely**PARTICIPATION** *Ratings based on progress-to-date and are reflective of changes in the client’s attitudes, beliefs, and behaviors as expressed in group and in homework assignments***:** |
| Select | **Engagement:** Participates constructively and actively, motivated, initiates dialogue, incorporates feedback from others |
| Select | **Awareness of Protective Issues:** Demonstrates awareness of protective issues, no minimizing and no denial |
| Select | **Communication:** Maintains respectful and considerate interactive style with peers when receiving feedback |

 **HOMEWORK -** *During this reporting period, client has completed homework.*

|  |  |
| --- | --- |
| Select | On time, as assigned |
| Select | Completely and thoroughly |
| Select | Applied homework topic to own case, as appropriate Examples:       |
| Select | If not completed, what were client’s reported challenges:       |

**TREATMENT GOALS-** *During this reporting period, parent has been able to:*

|  |  |
| --- | --- |
| Select | 1. Client is able to develop a written safety plan to protect self and child(ren) from IPV, including warning signs of abusive behaviors, identification of safety network, and action steps to implement safety planning strategies.Comments regarding progress:
 |
| Select | 1. Client is able to demonstrate understanding of the cycle of violence, types of abuse, role played in IPV dynamics.Comments regarding progress:
 |
| Select | 1. Client is able to demonstrate effects of IPV on child(ren)/parenting and identify effects on their children.

Comments regarding progress:       |
| Select | 1. Client is able to demonstrate the actions of protection over time in role as a parent.

Comments regarding progress:       |
| Select | 1. Client is able to demonstrate understanding of healthy/safe relationships and impact on child development.

Comments regarding progress:       |
| **ADDITIONAL TREATMENT GOALS (If indicated for this client):**Other:      Comments Regarding Progress:      Other:      Comments Regarding Progress:       |

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| **ADDITIONAL INFORMATION** (include any relevant information pertaining to readiness to change, curricula topics that have been covered, current risk factors/how risk has been reduced, strengths, any barriers to change, and other services that would be recommended):        |
| **DISCHARGE SUMMARY:** |
| Date of Discharge: Click or tap to enter a date. | Date SW Notified: Click or tap to enter a date. |
| Reason for Discharge: [ ]  Successful completion/met goals\* [ ]  Poor attendance [ ]  Office of Child Safety Case Closed [ ]  Other (specify):      \*Successful completion of treatment means that the client has achieved ratings of 4 or 5 for all components listed under Participation; Homework and Treatment Goals. |

**DIAGNOSIS:**

List the appropriate diagnoses. Record as many coexisting mental disorders, general medical conditions, and other factors as are relevant to the care and treatment of the individual.

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| **Mental Status/Psychiatric Symptom Checklist:**The following *current* symptoms were reported and observed:

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Angry mood | [ ]  Dissociative reactions | [ ]  Fatigue | [ ]  Isolation |
| [ ]  Anhedonia | [ ]  Distorted blame | [ ]  Flashbacks | [ ]  Memory challenges |
| [ ]  Anxious mood | [ ]  Distress and/or physiological reactions to trauma reminders | [ ]  Helplessness | [ ]  Psychomotor agitation |
| [ ]  Appetite disturbance | [ ]  Distressing dreams | [ ]  Homicidality | [ ]  Sleep disturbance |
| [ ]  Avoidance | [ ]  Euphoric mood | [ ]  Hopelessness | [ ]  Somatic complaints |
| [ ]  Concentration challenges | [ ]  Euthymic mood | [ ]  Hypervigilance | [ ]  Suicidality |
| [ ]  Depressive mood | [ ]  Exaggerated startle response | [ ]  Intrusive memories | [ ]  Other:       |
| [ ]  Derealization | [ ]  Fatalistic cognitions | [ ]  Irritable mood |  |

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| The Primary Diagnosis should be listed first. |
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| **ICD-10 Code** | **DSM-5-TR Diagnosis** |
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|       |       |
|       |       |
|       |       |
|       |       |

**Comments** (Include Rule Outs, reasons for diagnostic changes, and any other significant information):

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**PROVIDER INFORMATION**

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| --- | --- |
| Provider Printed Name:       | License/Registration #:       |
| Signature:       | Signature Date: Click or tap to enter a date. |
| Provider Phone Number:       | Provider Fax Number:       |
| ***Required for Interns Only*** |
| Supervisor Printed Name:       | License type and #:       |
| Supervisor Signature:       | Date: Click or tap to enter a date. |

Submit Group Progress Report Forms quarterly to Optum TERM at Fax: 1(877) 624-8376. Optum TERM will conduct a quality review and will be responsible for forwarding approved Quarterly Progress Reports to the CFWB SW.

Date faxed to **Optum TERM at: 1-877-624-8376**: Click or tap to enter a date.