Fax to Carelon Behavioral Health 248-697-0905

CDR Case Management Form

Print Form

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

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

Address: _____ Member ID# _____

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

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 representa ive 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: Carelon Behavioral Health at 248.697.0905