Organization Name:	**Program Name:**	
Individual's Name (First / MI / Last):	**Record #:**	**DOB**:

Type of Program:
☐ **CSU** ☐ **Respite Bed** ☐ **Overnight Substance Use Program** ☐ **Overnight Child/Adolescent Program**
☐ **Intensive Outpatient – Discrete Service Delivered** ☐ **Individual (= or > 25 min.)** ☐ **Group (= or > 60 min.)**
☐ **Outpatient Rehabilitation** ☐ **Other:**

☐ **Shift Note:** ☐1st Shift (Day) ☐ 2nd Shift ☐ 3rd Shift (Night) ☐ **Daily Note**

New Issues / Stressors / Extraordinary Events Presented Today: ☐ New Issue Resolved, No Update Required
☐ New Issue, CA/IAP Update Required ☐ None Reported
Explanation:

Goal(s)/Objective(s) Addressed As Per Individualized Action Plan:

Goal ___ Objective ___ Objective ___ Objective ___ Objective ___	Goal ___ Objective ___ Objective ___ Objective ___ Objective ___	Goal ___ Objective ___ Objective ___ Objective ___ Objective ___	Goal ___ Objective ___ Objective ___ Objective ___ Objective ___

Functioning (observed or reported):

Intervention(s) / Method(s) Provided ***(For IOP - Include how services addressed early recovery issues)*:**

Response to Intervention and Progress toward Goals and Objectives:

Plan / Additional Information:

Completed By - Print Staff Name/Credentials:	**Staff Signature:**	Date:
Supervisor - Print Name/Credentials (if applicable**):**	**Supervisor Signature:**	Date:

Date of Service	Staff Identifier	Loc. Code	Service Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Duration in Minutes