

# CDR CASE MANAGEMENT FORM

CDR Case Management Form      Revised 4/17/06 – Effective 4/17/06

<b>Demographics</b>		
CDR Number: _____ Assessment Coordinator Name: (please print name) _____		
Primary Enrollee Last Name: _____	First Name: _____	Contract Number: _____
Client Last Name: _____ First Name: _____ Date of Birth: _____		
Case Open Date: _____ Detox Related? YES / NO Extension Granted YES / NO Date of First Appt. Offered _____		

<b>Section A – Diagnostic Assessment Interview</b>		
Date of First Interview: _____ Did Client Show? YES / NO Date of Second Interview: _____ Did Client Show? YES / NO		
<input type="checkbox"/> 1 face to face CDR office (H0031) <input type="checkbox"/> 2 telephonic (H0031) <input type="checkbox"/> 3 face to face CDR office after hours (H2011) <input type="checkbox"/> 4 face to face @hospital (H0031) <input type="checkbox"/> 5 face to face hospital after hours (H2011) <input type="checkbox"/> 6 face to face @ OP provider (H0031) <input type="checkbox"/> 7 face to face OP provider after hours (H2011) <input type="checkbox"/> 8 face to face work/family rep office (H0031) <input type="checkbox"/> 9 face to face work/family rep office after hours (H2011) <input type="checkbox"/> 10 Assessment on a Holiday (H2011) <input type="checkbox"/> 11 Assessment on a Weekend (H2011) <input type="checkbox"/> 12 Second Diagnostic Interview (H0001) <input type="checkbox"/> 13 Detoxification Extension (H0009)		
<b>Outcome of Assessment (please check <input checked="" type="checkbox"/> one)</b>		
1. Reimbursable SA intervention accepted: _____ 2. Adjustment counseling referral: _____ 3. Closed (Complete Section D): _____		

<b>Section B</b> Mid-Treatment Review: YES / NO Closing Date _____ Date Client progressing satisfactorily? YES / NO  Date of Phone Review ( H0047): _____ Or Date of Face-to-Face Interview ( H0022): _____	<b>Section C</b> Discharge Planning: Yes / No Closing Date: _____  Date of Phone Review ( H0046) : _____ or Date of Face-to-Face Interview (H0032): _____
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<b>Section D – Closing Reasons and/or Outcomes</b>	
<b>Diagnostic Assessment (please check <input checked="" type="checkbox"/> one)</b> <input type="checkbox"/> 1. Client did not show or uncooperative, assessment completed <input type="checkbox"/> 2. Client did not accept recommendations <input type="checkbox"/> 3. Referral to Community Resource: (Complete Section F) <input type="checkbox"/> 4. Referral to mental health provider: Name: _____  <b>Mid-treatment Review (please check <input checked="" type="checkbox"/> one)</b> <input type="checkbox"/> 1. Client withdrew from service against CDR/medical advice <input type="checkbox"/> 2. Provider discharged client early, client did not cooperate <input type="checkbox"/> 3. Client needs more restrictive treatment <input type="checkbox"/> 4. Provider discharged client early, treatment satisfactory <input type="checkbox"/> 5. Other: _____	<b>Adjustment Counseling (please check <input checked="" type="checkbox"/> one)</b> <input type="checkbox"/> 1. Client did not show or uncooperative, assessment not completed <input type="checkbox"/> 2. Client did not accept recommendations <input type="checkbox"/> 3. Referral to Community Resource (Complete Section F) <input type="checkbox"/> 4. Referral to mental health or substance abuse provider <input type="checkbox"/> 5. Counseling completed no further treatment <input type="checkbox"/> 6. Case Reopened, additional sessions provided Name: _____  <b>Discharge Planning (please check <input checked="" type="checkbox"/> one)</b> <input type="checkbox"/> 1. Client withdrew from service against CDR/medical advice <input type="checkbox"/> 2. Provider discharged client early, client did not cooperate <input type="checkbox"/> 3. Client needs more restrictive treatment <input type="checkbox"/> 4. Provider discharged client early, treatment satisfactory <input type="checkbox"/> 5. Discharge planning process completed <input type="checkbox"/> Other: _____

<b>Section E – Adjustment Counseling (H0025)</b>		
Date of First Interview: _____ Date of Second Interview: _____ Date of Third Interview: _____		
Problem Description: (please check <input checked="" type="checkbox"/> at least one)		
<input type="checkbox"/> 1. Alcohol	<input type="checkbox"/> 2. Drug	<input type="checkbox"/> 3. Vocational/Occupational
<input type="checkbox"/> 4. Financial	<input type="checkbox"/> 5. Legal	
<input type="checkbox"/> 6. Emotional/Personal	<input type="checkbox"/> 7. Family/Marital	
<input type="checkbox"/> 8. Other (please describe) _____		

<b>Section F – Non Reimbursable Intervention (check <input checked="" type="checkbox"/> all that apply)</b>		
<input type="checkbox"/> 1. AA	<input type="checkbox"/> 2. CA	<input type="checkbox"/> 3. NA
<input type="checkbox"/> 4. COA/COA	<input type="checkbox"/> 5. Alanon / Alateen	<input type="checkbox"/> 6. Aftercare Group
<input type="checkbox"/> 7. Self Help	<input type="checkbox"/> 8. Other (please describe): _____	

<b>Section G – Work/Family Representative or EAP Representative Referrals</b>	
Was the client referred by the above representative? YES / NO Was referral made to the above representative? YES / NO	
Name: _____	

<b>Section H – Authorization Signature</b>	
Did client sign authorization consent form? YES / NO Date: _____	

Send completed forms to: ValueOptions, Attn: CareLine, One Towne Square, Suite. 300, Southfield, MI 48076 CDR FORM 4/17/06