(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: | | | Last Date Attended: | Number of  Sessions Attended: |
| Date of Absences: | | | Reasons for Absences: | |
| **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: | |

|  |  |
| --- | --- |
| **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: | Date SW Notified: |
| Reason for Discharge:  Successful completion/met goals\*  Poor attendance  CWS 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.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **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 |  | | |
| The Primary Diagnosis should be listed first. |
| |  |  |  |  | | --- | --- | --- | --- | | **ID (ICD-10)** | **Description** | **Corresponding DSM-5-TR Diagnostic Code or V Code** | **Corresponding DSM-5-TR Diagnostic Description or V Code Description** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |   **Comments** (Include Rule Outs, reasons for diagnostic changes, and any other significant information):   |  | | --- | |  | |

**SIGNATURE:**

|  |  |
| --- | --- |
| Provider Printed Name: | License/Registration #: |
| Signature: | Signature Date: |
| Provider Phone Number: | Provider Fax Number: |
| ***Required for Interns Only*** | |
| Supervisor Printed Name: | License type and #: |
| Supervisor Signature: | 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 CWS SW.

Date faxed to **Optum TERM at: 1-877-624-8376**: