



## CASE SUMMARY FORM

*\*Completed by Affiliate:* For couples and families, complete only once regardless of the number of participants in the session. Only include information from joint/family sessions. An additional Case Summary Form will be needed if a family member requires an individual treatment plan.\*

CLIENT'S NAME	CASE #

FAMILY INFORMATION
1. Family of origin strengths and/or concerns _____ _____
2. Nuclear family strengths and/or concerns _____
3. Cultural/Religious factors _____
4. Effects of drugs/alcohol on family _____

CASE ACTION PLAN
Measurable Goal 1 _____
Action Plan _____
Measurable Goal 2 _____
Action Plan _____
<input type="checkbox"/> Assessment and brief EAP problem resolution only <input type="checkbox"/> Assessment, brief EAP problem resolution & referral to community support services <input type="checkbox"/> Assessment and referral to long term treatment
Rationale for option selected: _____
Action Plan discussed with client? ____ Yes ____ No
Client agrees w/ Action plan? ____ Yes ____ No

CHECKLIST
Release of Information obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Necessary
<input type="checkbox"/> Signed Statement of Understanding for each client.

ASSESSED PROBLEM: <i>Check all that apply; circle the primary problem.</i>																								
Alcohol	Career Counseling	Childcare	Domestic Violence	Drug	Eating Disorder	Eldercare	Emotional	Familial	Financial	Grief/Bereavement	Housing	Legal	Marital	Occupational	Other's Alcohol/Drug	Other's Emotional Health	Other's Physical Health	Parent/Child	Physical Health	Relationship	Sexual	Workplace Violence	Other:	

CASE #

ABILITY TO FUNCTION					
1 (very poor) – 5 (very good)					
At Intake			At Case Closing		
Work	Home	GAF	Work	Home	GAF

REFERRAL OPTIONS									
A = Accepted R = Refused									
Community Resource: Mental Health or Substance Abuse	Insurance: Substance Abuse			Insurance: Mental Health			Other		
	Outpatient	Partial Hospital	Inpatient	Outpatient	Partial Hospital	Inpatient	Legal	Self Help	Financial

Referral Resource \_\_\_\_\_  
Phone Number \_\_\_\_\_

\_\_\_\_\_  
Affiliate Signature/Credentials

\_\_\_\_\_  
Date

**\*\*All requests for release of client records must be referred to First Advantage\*\***  
**\*\*First Advantage should be notified of any reports that are made to Protective Services.\*\***

For Corporate Office Use:
____ Assess & Refer
____ Assess & S.C.