Documentation Summary Form

Name of Patient(s)_____________________________________Date of Initial Contact: __________

Name of Initial Contact Person: ____________________________

- ❑ OCS Worker (Parish) ________________________
- ❑ Attorney ____________________________________
- ❑ Judge ______________________________________
- ❑ Parent ______________________________________
- ❑ Physician ___________________________________
- ❑ Therapist ___________________________________
- ❑ Other _______________________________________

TIPS #: ___________________ Age/DOB of Patient: _________

Reason for Referral: ______________________________________

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Date and Time of Appointment: ___________________________

Comments: ____

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Addresses:

Name/Relationship:

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Address:

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Telephone: ___________________

Name/Relationship:

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Address:

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Terlephone: __________________

Date(s) of Contact/Evaluation: ____________ ____________ ____________ ____________

Date(s) of Dictation: __________Date Sent to Typist: __________Date Returned: __________________

Date Edited: _______________ Date Mailed: _____________

- ❑ Rhonda
- ❑ Mary
- ❑ Sally
- ❑ John
- ❑ Other ____________________________

Scanned on :

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- ❑ John
- ❑ Mary File Name:

Notes re: Dictation:

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