ROSE STREET DAY TREATMENT PROGRAM
PHONE DOCUMENTATION RECORD

DATE: ____________________________________ TIME: __________________AM/PM

PERSON MAKING CALL: ____

PATIENT'S NAME: ____ DOB: ____________________

AGE/GRADE: ________________________________ HOME CAMPUS: _______________________

PHONE NO: ________________________________ ASSESSMENT DATE: ____________________

CURRENT STATUS: ____

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WHO REFERRED YOU TO OUR PROGRAM? ______________________________________

HAS THE PATIENT SEEN A THERAPIST BEFORE? YES / NO ____________________________

WHEN WAS THE PATIENT LAST SEEN? ____________________________________

HAS THE PATIENT BEEN HOSPITALIZED FOR PSYCHIATRIC REASON BEFORE? YES / NO

WHEN: __________________________________ WHERE: _________________________________

WHAT INSURANCE DO YOU CARRY? ____

FACING TIME @ DENVER OR AEP? ____

CURRENT MEDS /DOSAGE / PRESCRIBER ____

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OTHER COMMENTS: ____

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SIGNATURE