MULTIDISCIPLINARY TREATMENT TEAM
Case Presentation

Consumer: _____ Chart No.: _____
Date of Birth: _____
Review Number (First, Second, etc) _____ Date: _____

1. Reason for Presenting (check all that applies):

a.	**Diagnostic Issue**	**[ ]**	**e.**	**Information Updated**	**[ ]**
b.	**Medication Concerns**	**[ ]**	**f.**	**Teamwork Concerns**	**[ ]**
c.	**Treatment Plan**	**[ ]**	**g.**	**Follow-up**	**[ ]**
d.	**Compliance Issue**	**[ ]**	**h.**	**Other:**	

2. Description of the client and his/her presenting problem (includes age, so, etc).

_____

3. Brief social, medical, psychiatric and other relevant history (include current. medication)

_____

_____

_____

4. Diagnosis (DSMIV Codes)

Axis I : _____
Axis II : _____
Axis III : _____
Axis IV: _____
Axis V: _____

5. List other Providers (internal and external) and indicate primary clinician.

_____

_____

_____

6. Course of Treatment (Treatment Plan, etc).

_____

_____

_____

(use back page if needed)

MULTIDISCIPLINARY TREATMENT TEAM Case Presentation/Documentation

FACILITATOR _____
CONSUMER _____ **CHART NO.** _____
CONSULTANT (PSYCHIATRIC/MEDICAL STAFF) _____
SERVICE PROVIDERS (BRANCH/UNIT) _____
REVIEW SCHEDULE (FIRST, SECOND, ETC.) _____

PROBLEMS/ISSUES PRESENTED	TREATMENT PLAN/RECOMMENDATION AND DISPOSITION	
1	1	
	STAFF	
	DATELINE	
2	2	
	STAFF	
	DATELINE	
3	3	
	STAFF	
	DATELINE	
4	4	
	STAFF	
	DATELINE	

SIGNATURES:

Primary Clinician _____

Print Name **Signature/Date**

Consumer _____

Print Name **Signature/Date**

Psychiatrist _____

Print Name **Signature/Date**

Follow-up Meeting Date: _____

Disposition/Closure Comment:

_____

_____

_____

_____ _____

Facilitator's Signature **Date 03/18/05**