Solano County Medi-Cal

Closing Summary Report

Please complete following the last session and fax or mail to:
Solano County Managed Care Program
275 Beck Ave. MS 5-235
Fairfield, CA 94533-0677
Phone: (800) 547-0495 FAX: (707) 425-4320

Please type or print clearly and complete this form in its entirety. For entries marked with an asterisk (*), use the Authorization for Service letter you received to obtain the necessary information.

Client Information

Client Name* (First & Last)	Authorization Number*	Date Last Seen
Guardian/Parent Name	Client's Date of Birth*	Total # of Sessions You Have Client Seen
Client's Home Phone / Work Phone	Medi-Cal Number	Other Insurance (e.g., Medicare, HMO)
Client's Primary Care Physician	Initial Telephone Contact Date	Evaluation Date

Provider Name	Provider Phone	Provider Fax	Provider Email Address

Symptoms & Problems

Severity Rating: **1 = Mild** **2 = Moderate** **3 = Severe**

	Severity		Severity		Severity
Anxiety		Poor Interpersonal Skills		Sexual Dysfunction	
Appetite Disturbance		Poor Judgment		Sleep Disturbance	
Bizarre Behavior		Impaired Memory		Somatization	
Conduct Problems		Obsessive-Compulsive		Indep. Living Problems	
Depression		Panic Attacks		Poor Self-Care Skills	
Gender Issues		Paranoid Ideation			
Bizarre Ideation		Phobia			

Current Medication

☐ None ☐ Psychiatric ☐ Physical ☐ No Information

Medication Name	Dosage	Frequency	Compliance	Prescribing Physician

Current Diagnosis (check only one Primary Diagnosis)

Axis I ☐ Pri ☐ Sec DSM Code: ________ Name: ________

Axis II ☐ Pri ☐ Sec DSM Code: ________ Name: ________

Axis III General Medical Condition ICD Code: ________ Name: ________

Axis IV Psychosocial and Environmental Problems ***Check all that apply***:

☐ A. primary support group
☐ B. social environment
☐ C. education
☐ D. occupational
☐ E. housing
☐ F. economics
☐ G. access to health care
☐ H. interaction with legal system
☐ I. other psychosocial/environmental
☐ J. inadequate information

Axis V Current **GAF**: ________ Highest **GAF** (in past 12 months): ________

Transition/Termination Plan

Referrals & Recommendations (Check all that apply):

☐ Individual Therapy ☐ Structured Treatment Program ☐ No continuing care recommended

☐ Community/Self-Help Support ☐ Family/Couple Therapy ☐ Medication Management

☐ Residential Treatment ☐ Other (Specify): ____________ ☐ Other (Specify): ____________

Please list community resources that have been discussed with client as well as those resources the client has connected with that will aid them following termination from your services: ____

Reason for Submitting Closing Summary Report

☐ Treatment goals met ☐ Provider discontinued treatment ☐ Member discontinued treatment

☐ Annual benefit maximum reached ☐ Lack of ongoing medical necessity ☐ Client death

☐ Other (Specify): ____________

Treatment Plan

Treatment goals must be specific observable and/or specific quantifiable. You should be able to tell when the client has reached their goal, e.g. "as evidenced by…"

Goal #1: ____

Method for Achieving Goal/Interventions: ____

Progress Since Last Report:

☐ Much Worse ☐ Slight Improvement

☐ Somewhat Worse ☐ Significant Improvement

☐ No Change ☐ Resolved

Goal #2: ____

Method for Achieving Goal/Interventions: ____

Progress Since Last Report:

☐ Much Worse ☐ Slight Improvement

☐ Somewhat Worse ☐ Significant Improvement

☐ No Change ☐ Resolved

Additional Comments

____

____

Provider Signature and Licensure/Degree Date Print Provider Name and Licensure/Degree