MONTHLY OUTPATIENT COMMITMENT STATUS REPORT

Reporting Period: Court Case No.:

Consumer Name: Social Security No.:

Date of Most Recent Commitment:

Date Commitment Expires:

Current Address:

Primary Agency Providing Outpatient Treatment:

Treating Psychiatrist: Phone:

Case Manager/CTT: Phone:

Diagnosis:

(Axis I, Axis II, Axis III)

**CURRENT CLINICAL DATA** **CIRCLE RESPONSE (IF NO, EXPLAIN)**

Any change(s) in mental status? Y N NA

Is client compliant with medications? Y N NA

Regularly attends CM appointments? Y N NA

Regularly attends psychiatrist appointments? Y N NA

Regularly attends other appointments? Y N NA

Significant issues pertaining to behavior, ongoing treatment, compliance:

Has the person been hospitalized? Y N Admission date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If commitment is within two months of expiring, do you intend to request continuation of commitment? Y N NA

Case Manager’s signature: Date:

Supervisor’s signature: Date:

Psychiatrist’s signature: Date:

Comments from Medical Director/Clinical Director:

Medical/Clinical Director’s signature: Date: