NEW AVENUES / MBHN: Case Closing Summary

❐ EAP
❐ MBHN

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Client Name: ________________________ **DOB:** __________ **# of Sessions Held:** _______ **# of Cancellations/No Shows:** _____ **Date Case Closed:** ___________

Employee's Name: ____________________________________ **Policy ID:** _______________________ **Employer Name:** ______________________________

Presenting Problem: ____

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Evaluation Question: To What Extent Did The Client Experience A Positive Change When It Came To Resolving The Above Presenting Problem?

❐ 1.0 No Change: The client appeared to experience NO POSITIVE CHANGE for this problem.
❐ 2.0 Mild Change: The client appeared to experience A LITTLE POSITIVE CHANGE for this problem.
❐ 3.0 Moderate Change: The client appeared to experience SOME POSITIVE CHANGE for this problem.
❐ 4.0 Pronounced Change: The client appeared to experience MARKED POSITIVE CHANGE for this problem.
❐ 5.0 Problem Resolution: The client appeared to RESOLVE this problem completely

Goals Achieved:

1.____ **2.**____

3.____ **4.**____

Using the above rating scale to evaluate the Clinical Status of the above goals and place a NUMERICAL RATING beside each Treatment Goal below.

1.0 ---------- 1.5 ---------- 2.0 ---------- 2.5 ---------- 3.0 ---------- 3.5 ---------- 4.0 ---------- 4.5 ---------- 5.0
No Change — Mild Change — Moderate Change — Pronounced Change — Problem Resolution

Treatment Goal #1: _________ **Treatment Goal #2:** _________

Treatment Goal #3: _________ **Treatment Goal #4:** _________

Disposition at last EAP Visit: ❐ Resolved ❐ Improved ❐ Unimproved **Continued Treatment Into Mental Health Benefit:** ❐ Yes ❐ No ❐ Declined

Type of Behavioral Health Referral: ❐ Individual ❐ Family/Marital ❐ Alcohol/Drug Treatment ❐ Psychiatric ❐ Medical Care ❐ Other/Self Help Groups

Referral Details: ____

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EAP CLIENTS ONLY

MBHN Case Closing Status: ❐ Client Assessed: No Treatment Indicated ❐ Client Successfully Completed Treatment ❐ Client Discontinued Therapy – "No Show"
❐ Client Chose to Terminate Therapy ❐ Client Relocated ❐ Client Lost Benefit Eligibility ❐Other: ______________________________________

Discharge Primary Diagnosis: ___________Description:______ ____________________ **Secondary Diagnosis**: __________ Description: _________________________

Co-Morbid Diagnosis: ________Description____________________________

Prognosis: ____

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Discharge Recommendations: ____

MBHN CLIENTS ONLY

Provider's Name:(print) ___________________________________ **Provider's Signature:** ____ **Date Signed:** _______________