**Fountain of Hope Family Services**

**180 Day Case Conference**

Client: Admit Date: Today's Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicald/Case No: Primary Counselor:

Behavioral Health Dx: AXIS I ( ) ( )

**CODE DESCRIPTION CODE DESCRIPTION**

Co-existing Disorder(s) Identified:

**STAFF OBSERVATIONS Thought Content/Perceptions:**

Logical & Linked Normal Thought Process Suicide Attempts Thoughts of Self Harm Thoughts

of Harm to Others Hostile Delusions Disorganized Paranoid Grandiose Flight of

Ideas Obsessive Compulsive Auditory Hallucinations Visual Hallucinations

**Other:**

**Please Describe**

**Affect:**

Appropriate Agitated Angry Blunted Flat Tearful Fearful Animated

Intense Constricted Irritability Out of Control Anxious Sadness Withdrawn

Reluctant Hyperactive Distracted **Other:**

**Please Describe**

**Appearance:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Neat Clean Appropriately | Dressed Well | Groomed | Disheveled | Poor Hygiene |
| Underweight Overweight | Seductive | Older than | Younger than |  |
| Other: |  |  |  |  |
| Please Describe  Orientation: | Situation Other: | | | |
| Time Person Place |
| Mood: |  | Please Describe  Engaged Depressed | | Suspicious |
| Cooperative Calm Anxious Cheerful | |
| Labile Hostile Dramatic | Euphoric | Mood Swings | Evasive | Disruptive |
| Uncooperative Other: |  |  |  |  |

**Please Describe**

**Insight:**

Good Fair Superficial Lacking \_ Poor Blaming Improved insight\_\_\_\_\_\_

Improved Out Look on Life Improvement in Behaviors **Other:**

**Please Describe**

**RECOMMENDATIONS:**

Continued Services Discharge Referral for other services\_

**Please Describe**

**New Tx Issues Identified / Additional Comments / Strengths-Needs-Abilities-Preferences:**

Discharge Date: Discharge Plan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff: Staff:

Signature and Credentials Signature and Credentials

Staff: Staff:

Signature and Credentials Signature and Credentials

Staff:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staff:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Form/FOHFS/143 (Revised 0903/2016)