



CLINICAL PROGRESS REPORT

PATIENT NAME: _____

PROVIDER NAME: _____

INSURED'S EMPLOYER: _____

The purpose of this report is to identify patient's progress or lack of progress on specified goals and objectives, signs and symptoms, and level of functioning. HIPAA allows release of this information for payment purposes.

Date: ____/____/____

PROGRESS/OBSERVATIONS: _____

Duration: _____
(minutes)

Score this visit: _____
(see scale below)

GOALS ADDRESSED: _____

GOALS/PLANS FOR NEXT VISIT: _____

PROVIDER SIGNATURE

Date: ____/____/____

PROGRESS/OBSERVATIONS: _____

Duration: _____
(minutes)

Score this visit: _____
(see scale below)

GOALS ADDRESSED: _____

GOALS/PLANS FOR NEXT VISIT: _____

PROVIDER SIGNATURE

Date: ____/____/____

PROGRESS/OBSERVATIONS: _____

Duration: _____
(minutes)

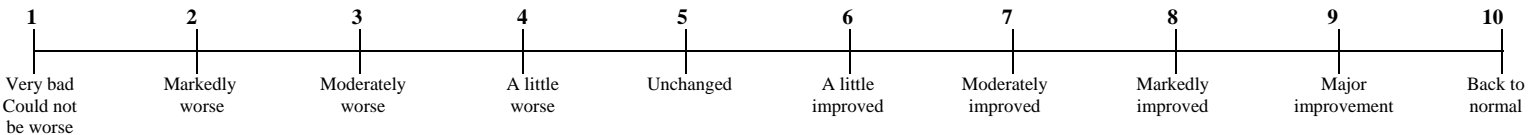
Score this visit: _____
(see scale below)

GOALS ADDRESSED: _____

GOALS/PLANS FOR NEXT VISIT: _____

PROVIDER SIGNATURE

Instructions: Refer to the scale below and indicate above the score that best describes the patient's overall condition at the time of each visit.



NOTE: IF PATIENT'S CONDITION WARRANTS A REVIEW OF THE TREATMENT PLAN, ITS DURATION OR FREQUENCY, PLEASE CONTACT THE BHS CLINICAL CASE MANAGER.