PROVIDER REQUEST FOR CASE CLOSING

Consumer: ______________________________ Case #: _____________________

Referring Agency: _______________________ Referring Clinician: __________________

Service Requesting Closure: _______________________________________

Service being referred to: ____

Is consumer taking psychotropic medication: ____ yes _____no

If yes, prescribing physician: _________________________________

Is this person being referred for "Medication Only" treatment? ___ yes ____ no

Date consultation occurred with treating psychiatrist: ________________

Did this consumer successfully complete treatment with your agency? ____yes ____ no

Is this consumer's mental health condition currently stable? ____yes _____no

Has the consumer received intensive services (inpatient, crisis residential) in the past year?
_____ yes ______no.

If consumer is not stable, did not successfully complete treatment and/or has utilized intensive services in the past year, record date that closing was approved by your agency's Behavior Risk Committee. ________________.

All recommendations for closure by the agency's Behavior Risk Committee **MUST** then be approved by LifeWays Behavior Risk Committee. Date of LifeWays BRMC review: _________

------------------------------- LifeWays Use ---

Date of UM consultation with treating psychiatrist: __________________

______ Closing approved (provider may enter discharge event)

______ Medication Only Referral Accepted

______ Closing not approved - Requesting Person Centered Planning meeting with consumer

**** Please send original to Vanessa Davidson and a copy to PSU if applicable.**