CIVIL COMMITMENT REPORT/TREATMENT PLAN UPDATE

Reporting Period: ______________________ UCI#: ______________

Client Name: ______________________ Court Case #: ______________

Client Case Number: ____________ Date of Commitment: ____________ Date Expires: ____________

Case Manager/Therapist: ______________ Psychiatrist: ______________

Diagnoses: ______________________________

Is client currently in hospital/CSU? No ______ Yes ______ If yes,

Identify hospital setting: ______________ Date of Hospital Admission: ______________

For clients on Outpatient Commitment, document pertinent history supporting need for commitment (past history of dangerousness to self or others, multiple hospitalizations, etc.)

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In case manager's opinion, does this patient meet all (10) clinical criteria for outpatient commitment? No ______ Yes ______

Considering the range of circumstances that influence this client's ability to respond to treatment has he/she sufficiently complied with treatment recommendations to be discharged from involuntary commitment? No ______ Yes ______

Explain: ______________________________

Is client receiving ACT: Yes ______ No ______ or Regular Case Management: Yes ______ No ______
Residential Treatment: Yes ______ No ______ Is client receiving Adjunctive Services: Yes ______ No ______

Compliant with:

1. Case Management Yes ______ No ______ N/A ______ # Contacts ______ # Attempts ______

   Comments ______________________________

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2. Psychiatric Care

   Clinic Appointments Yes ______ No ______ N/A ______ # Appts. Kept ______ # No Shows ______

   Medications Yes ______ No ______ N/A ______ Long acting antipsychotic (Injection) Yes ______ No ______

   Current Medications: ______________________________

   Method of Verification: Client ______ Significant Other ______ Treatment Team ______

   Comments: ______________________________

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3. Vocational/Partial Program Yes ______ No ______ N/A ______ # of Contacts: ______

   Method of Verification: Client ______ Staff ______

   Comments: ______________________________

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4. Day Treatment Program Yes ______ No ______ N/A ______ # of Contacts ______

   Method of Verification: Client ______ Staff ______

   Comments: ______________________________

Has it been necessary to request that Probate Court transport the client to Portage Path Psychiatric Emergency Services (PES) for a court ordered evaluation?
Yes_____ No_____

Has this client been rehospitalized in the past (30) days? No ______ Yes ______

If yes, indicate if hospitalization was in a State Hospital ______ a general hospital ______, psychiatric unit______, or CSU _____

Has client been incarcerated in the last (30) days? No ______ Yes ______ Location: ______________________________

Significant changes: (Change in client's circumstances over the last (30) days i.e. job loss, marital problems, change of residence, drug screens performed) ____

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Is there reason to consider returning this client to an inpatient commitment status? No __________ Yes__________

Explain:____

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Are there changes in service recommendations that would enhance his/her ability to effectuate discharge from involuntary treatment? No ______ Yes _______ Explain______________________________________

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Document changes in the treatment plan.____

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If commitment is in final month, do you intend to ask Probate Court to extend commitment? Yes_____ No _____ N/A _____

Case Manager's Signature: ________________________________ Date: ______________

Supervisor's Signature: ________________________________ Date: ______________

Psychiatrist's Signature: ________________________________ Date: ______________

Comments from Clinical Director: ________________________________ Date: ______________

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Clinical Director's Signature: ________________________________ Date: ______________