KAS Service Encounter Form/ Summary Documentation

Provider Name: ______________________  Participant Name: ______________________

Date of Service: ______________  Start Time: ______________  End Time: ______________

Were any health/safety risk factors assessed in this session? ______Yes    ________No

If yes, specify risk factors (e.g., suicidal ideation, homicidal ideation, psychotic symptoms):

Goals/ Objectives Addressed In This Session:

Goal Data (subjective/objective/reported) from session:

Interventions used, clinical assessment, progress assessment:

Plan for Follow-Up/Summary of Clinical Needs:

Provider Signature  ______________________  Date ______________

Participant Signature  ______________________  Date ______________

(Your may sign above or on a separate encounter form)

Created December 2015; Revised 9/2019