



## 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 \_\_\_\_\_

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