Behaviorial Health
Client List

Facilitator Name: _____ **Date last updated:**

*Document to be EMR

Client Name	ID Number	Funding	Description of Services Referred	Therapist	Rcvd Referral (Date)	d or closed (Date)	Referred for Wrap	Rcving wrap		SNCD*	Family Team Roster*	Plan of Care*	Crisis/ Safety Plan*	Transition Plan*	Transition out of Wrap

FORM NO. UFC-005 *(last updated 12-1-14)*

Client Name	ID Number (s)	Funding	Description of Services referred	Therapist	Referral (Date)	closed or completed (date)	Referred for Wrap?	Rcving wrap?	Family Team?	SNCD in file?	Team Roster in file?	Plan of care in file?	Crisis/ Safety Plan in file?	Transition plan in file?	Transitioned out of Wrap