



(ENCOUNTER FORM)

ENCOUNTER DATE: ___ / ___ / ____ (mm/dd/yyyy)

(URN)

SERVICE NAME

Linkage Case Management Other: _____

TYPE OF ENCOUNTER

- Phone Call Letter Face-to-face Home Visit E-mail
 Other: _____

Time of appointment: _____ a.m. / p.m.

Person attempted to reach:

- Client/Out-of-Care individual Alternative Contact 1 Alternative Contact 2

ACTION TAKEN

- | | |
|--|--|
| <input type="checkbox"/> Linkage to medical care
Specify: _____ | <input type="checkbox"/> Linkage to non-medical care
Specify: _____ |
| <input type="checkbox"/> Client received copy of medical care linkage consent form | <input type="checkbox"/> Client received copy of non-medical care linkage consent form |

*Date of creation of Session Plan: _____

Date of release from prison: _____

Service Comments/Session Notes:

Employee's Name: _____ (First) _____ (Last)