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

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

☐ Linkage to medical care

Specify: ________________________________

☐ Linkage to non-medical care

Specify: ________________________________

☐ Client received copy of medical care

linkage consent form

☐ Client received copy of non-medical care

linkage consent form

Service Comments:

Employee’s Name: ___________________ (First) ___________________ (Last)