

CALL LOGGING

First Name	_____	Middle Name	_____
Last Name	_____	System of Care	<input type="checkbox"/> MH <input type="checkbox"/> ADP <input type="checkbox"/> MCO

Caller Name	_____	Caller Relation	_____
Phone #	_____	Requested Language	_____
Requested Program	_____	Program ID	_____
Requested Provider	_____	Provider ID	_____
Begin Date	_____	End Date	_____
Begin Time	_____	End Time	_____
Elapsed Time	_____		

Type of Contact	_____	Call Type	_____
Type of inquiry	_____	Emergency Type	_____
Danger to self or others	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

Presenting Problem _____

Disposition _____
 Final Disposition/
 Action Taken _____

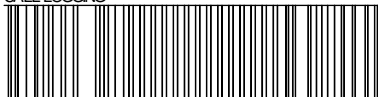
Other Comments _____

Follow-up Required Yes No Follow-up Date _____

Follow-up Completed Date _____

USER _____ User ID _____

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CARES / OA 03092007