Community Mental Health for Central Michigan

HOME PROVIDER'S MONTHLY REPORT

Consumer Name: _____ **Residence:** _____

Case #: _____ **Case Manager:** _____ **Month/Year:** _____

Current Weight: _____ **Previous Weight:** _____ **Date of Birth:** _____

Prescribed Diet Changes: ☐ Yes, please explain below ☐ No ☐ N/A

Medication Changes (list Start, Stop Dates/Physician and Reason): ☐ Yes ☐ No

Seizures: ☐ Yes ☐ No ☐ N/A

Date	Duration

Medical Contact (physician, dentist, vision, hearing, OT, PT, psychiatrist, specialist, etc.):

Date	Doctor/Clinic	Recommendations

Trips, Vacations, Outings: Complete Community Events/Activities on Reverse

Family/Guardian Contacts: ☐ Yes ☐ No

Comment:

Concerns, Needs or Other Comments:

1. _____
2. _____
3. _____

Report completed by: _____ **Date:** _____

Case Manager Review: _____ **Date:** _____

Community Events/Activities

Consumer Name: _____ **Case #:** _____ **Month/Year:** _____

Date	Provider Offered/ Consumer requested (P/C)	Independent with Staff or Natural Support (I, S, N)	Individual/ Group Outing (I, G)	Community Event/Activity	Where/City	Participated + or -	Liked + or Disliked -	Reason for not attending?	Total Hours	Staff Initials

Case Manager Signature: _____ **Date:** _____