



Community Mental Health for Central Michigan

Closing Report - CIGMMO

USE THIS FORM ONLY IF ALL AGENCY SERVICES ARE BEING TERMINATED

CLOSING REPORT			
NAME	CASE #	DOB	GENDER
ADDRESS			
SERVICE	DATE	TIME	

Doctor Review Required
 Closing Letter Sent?
 Medication Summary Log Attached?

DATE OPENED	DATE LAST SEEN	DATE CLOSED	COUNTY/AFFILIATE
LAST SERVICE DATE			

DIAGNOSIS					
	ICD9	ICD10	DESCRIPTION	STATUS DATE	STATUS
AXIS I					
AXIS II					
AXIS III					
AXIS IV	<input type="checkbox"/> Economic problems <input type="checkbox"/> Problem with primary support group <input type="checkbox"/> Problem accessing healthcare <input type="checkbox"/> Problem related to social environment <input type="checkbox"/> Educational problems <input type="checkbox"/> Problem related to interaction with legal system <input type="checkbox"/> Occupational problems <input type="checkbox"/> Other psychosocial and environmental problems <input type="checkbox"/> Housing problems <input type="checkbox"/> Behavioral/personality issues				
AXIS V	CURRENT GAF	DATE	SIS SCORE	DATE	
	EXCEPTIONAL MEDICAL SCORE		EXCEPTIONAL BEHAVIORAL SCORE		
DIAGNOSTIC SUMMARY					
ADDITIONAL INFORMATION	CO-OCCURRING CONSUMER QUADRANT				
	CO-OCCURRING CONSUMER QUADRANT COMMENTS				
	DIAGNOSIS MADE BY/REVIEWED BY			EFFECTIVE DATE	
Non-psychiatric diagnoses are recorded as reported by the Consumer and/or by the primary health care provider					

DISABILITY DESIGNATION

DEVELOPMENTAL DISABILITY

Yes No

MENTAL ILLNESS

Yes No

PRIMARY DESIGNATION

Yes No

SUD

No SUD

Not Evaluated for SUD

1 or more SUD Dx Codes active or in partial remission
(use within past year)

1 or more SUD Dx Codes with all SUD Dx codes in full remission
(no use for 1 year)

Results from screening suggest SUD

INDIVIDUAL RECEIVED AN ASSESSMENT ONLY AND WAS FOUND TO MEET NONE OF THE DISABILITIES LISTED ABOVE

Yes No

FURTHER SERVICE RECOMMENDATIONS OR REFERRALS

INCLUDE DATE OF FOLLOW-UP AND WITH WHOM, WHEN APPROPRIATE

CLOSING REASON

CLOSING SUMMARY

CONSUMER SATISFACTION

SATISFACTION WITH SERVICES RENDERED

- Satisfaction with services, supports and/or treatment not discussed.
- Satisfaction with services, supports and/or treatment discussed; consumer or representative satisfied.
- Satisfaction with services, supports and/or treatment discussed; consumer or representative not satisfied.

Explanation (use direct quotes from consumer, when possible):

Please remember to cancel any future appointment(s) scheduled.

Please remember to early terminate authorizations as of the discharge date.

Please end all consents upon closing.

For children: Please remember to complete Exit CAFAS/PECFAS, mark "No subsequent assessment due" and inactivate in FAS system.

SIGNATURES

STAFF SIGNATURE/CREDENTIALS

DATE

CONSUMER SIGNATURE

PRINTED NAME

DATE

PARENT/GUARDIAN/FAMILY MEMBER SIGNATURE

PRINTED NAME

DATE

SUPERVISOR SIGNATURE/CREDENTIALS

DATE

PHYSICIAN SIGNATURE/CREDENTIALS

DATE