

Fountain of Hope Family Service Inc.
10326 Greenbriar Parkway
Oklahoma City, Ok 73159

CLINICAL DOCUMENTATION FORM

DATE/TIME: _____

MEETING TYPE:

- TEAM STAFF MEETING** **GROUP SUPERVISION** **INDIVIDUAL SUPERVISION**

SUPERVISED/LEAD BY: _____

PARTICIPANTS:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ISSUES IDENTIFIED: (Assmt & Referral Skills; Interventions & Effectiveness; Issues of Ethics, Legal, or Boundaries, Cultural Competencies; Communication Internal/External; Case Management; Coordination of Services; or document other discussion)

FEEDBACK OR FOLLOW-UP ACTION NEEDED:
