# CROSSROADS TO INTERVENTION
## PATIENT SERVICE RECORD

**Client Name** ___________________________  **ID #**

### Therapeutic Services

1. Initial Assessment/Process  
2. Individual Counseling  
3. Case Management  
4. Open Group  
5. Didactic Groups  
6. Family Counseling  
7. Family Groups  
8. U/A Screening OBS  
9. U/A Results  
10. Treatment Planning  
11. Monthly Case Review  
12. Medical Director Consult  
13. POI/POR  
14. Family Support  
15. Education Advocacy  
16. Referrals

Written clinical documentation shall be recorded in the progress notes to support each service rendered.

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**Primary Counselor Signature/Date**

**Program Director Signature/Date or Treatment Services Director**