MH 712
Revised 3/24/17

DAY TREATMENT INTENSIVE WEEKLY CLINICAL SUMMARY

Week of: ____

Summary of Mental Health Interventions Provided:

Status of Client *(Symptoms/Behaviors/Impairments Justifying Continued DTI Services)*:

Plan *(Interventions Modified, Additional Behaviors Addressed)*:

Did a family member/caregiver/significant support person contact occur this week outside of regular DTI hours? (At least one contact per month required. Adult clients may refuse this option.)
☐ Yes ☐ No If yes, describe interaction or reference relevant Daily Note.

Was psychotherapy provided this week?
☐ Yes ☐ No If yes, describe the therapy or reference relevant Daily Note or separate Progress Note. If no, provide the specific, individualized reason why it was not.

Staff Signature*	Date	Co-Signature*/Co-Practitioner	Date

*Must include Degree/Discipline/Title and License/Certification/Registration Number (if applicable)

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: **ID#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

DTI WEEKLY CLINICAL SUMMARY