

VERBAL CONTENT OF PRESENTATION (sample)

Reason for Presentation
periodic review, disposition, problem specific, etc.

Identifying Data
admission date, personal demographics including
living situation, family information

Presenting Problem(s)
client's presenting complaint, service staff's perceptions
including behavioral and symptomatic manifestations

History relevant psychosocial, medical, and psychiatric

Diagnosis
review supporting diagnostic criteria

Current Service Plan
short and long-term goals, service modality
and approach, estimated duration, medications

Family/Service Staff Relationship
cultural/language issues, psychodynamics

Progress Towards Goals
factors leading to or interfering with change

DOCUMENTATION

Required minimum: Date of presentation, Reason for presentation, Issues discussed, Service suggestions

Multiple horizontal lines for documentation entry.

Signature (primary service staff/supv. when required) and Discipline

This confidential information is provided to you in accord with applicable Welfare and Institutions Code Section. Duplication of this information for further disclosure is prohibited without the prior written consent of the patient/ authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

MIS#:

Agency:

Los Angeles County - Department of Mental Health

CASE PRESENTATION

CASE PRESENTATION

Purpose: This form provides a unique place for the documentation of any one of a variety of formal staff conference activities: Interdisciplinary case conferences, periodic case reviews, problem case conferences, case training conferences, disposition conferences, transfer conferences, intake conferences, etc. In essence, it is the form that should be used to document any case conference activities that occur in a provider.

Verbal Content of Presentation: These sample items are not intended to set minimum standards or requirements for a presentation. It is intended primarily to assist students and new professionals in preparing a presentation. Many conferences will have a focus that does not include all of the elements listed, such as a conference focused on a discharge plan. Other conferences may specifically include areas not noted, but relevant to the type of conference or presentation.

Recording Procedure: The Documentation section is intentionally brief. It was designed to highlight only the issues discussed and service suggestions made at the presentation. There are a variety of other places in the service record where summaries of the patient, his/her service, or any other aspects of the case may be found. In the face of ever increasing demands on service time, it seemed unnecessary to repeat this information, thus the focus on the discussion aspect of the case conference and information which may not be available elsewhere in the service record. Individual programs may require additional documentation by specifying required content in service procedures.

If additional space is needed, use a *Progress Notes* page. Cross out any unused space at the end of the case presentation documentation.

Reason for Presentation: This should be a brief statement (such as problem specific, periodic review, interdisciplinary case conference, disposition, etc.). If the presentation is problem specific, a brief statement of the problem should follow.

Signature: The service staff presenting the case should complete and sign the form. Supervisors are encouraged to review conference documentation of their supervisees. All student/trainee notes must be co-signed by his/her licensed supervisor.

Filing Procedure: This form should be filed sequentially in the progress notes section of the service record.

**COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
INDIVIDUALIZED SERVICE DELIVERY SUPERVISION PLAN**

I. IDENTIFYING INFORMATION

Employee Name: _____
First Last

Unit: _____

Discipline: _____ Ph.D. _____ M.S.W. _____ M.D. _____ R.N.

Other: _____

Licensed: _____ Yes _____ No

Staff Category: _____ Probationer until _____
 _____ New Employee for 3 months ending _____
 _____ Medi-Cal Reimbursable, Licensable or Registered
 _____ Waivered Psychologist or Social Worker
 _____ Adjunctive Therapist
 _____ Unlicensed
 _____ Student, Intern, Trainee
 _____ Volunteer

Employee Status: _____ Full-Time _____ Part-Time (Specify)

II. FORMAL SUPERVISION/CONSULTATION

Type	Frequency	Conducted by	Title	Date(s) of Actual Supervision
_____ Individual Performance Centered Supervision/ Consultation	_____	_____	_____	_____
_____ Case Staffing	_____	_____	_____	_____

Type	Frequency	Conducted by	Title	Date(s) of Actual Supervision
_____ Special Clinical Problems Presentation/ Conference	_____	_____	_____	_____
_____ Inter- Departmental Case/Centered Conference	_____	_____	_____	_____
_____ Staff Meeting with Case Centered Focus	_____	_____	_____	_____
_____ Medical Supervision	_____	_____	_____	_____
_____ Other(Specify)	_____			

III. OTHER TRAINING/PROFESSIONAL DEVELOPMENT ACTIVITIES

List any other training or professional development activities which are part of the plan.

a. _____

b. _____

c. _____

I have developed this plan with the supervisor and agree.

Supervisee

Date

I have developed this plan with the supervisee and agree to ensure that it is adhered to.

Supervisor

Date

I approve the above plan.

Unit Administrator

Date

c: Unit Administrator
Office File
Employee

**QUARTERLY REPORT
VERIFICATION OF SUPERVISION PROVIDED DURING WAIVER PERIOD**

Quarter Beginning _____ Date of Submission: _____

Quarter Ending: _____ Employee # _____

Name: _____

Work Location: _____

Address: _____

Telephone No. _____

Service Delivery Supervisor _____ Discipline: _____

Address: _____

Telephone No. _____

**Total hours of Service Delivery
Supervision provided this quarter:**

**Total Supervised Hours
provided this quarter:**

Factors having potential impact on Waiver period: _____

- None
- Change in Service Delivery Supervisor Date: _____
- Leave of Absence Date began: _____ Date ended: _____
- Extended Medical Leave Date began: _____ Date ended: _____
- Transfer to non-service delivery program Date: _____
- Completed supervised hours for licensure Date: _____
- Other

Worker needs additional Training/Experience Yes No

If yes, please explain: _____

Signature of Service Delivery Supervisor: _____ Date _____

Please forward form to County of Los Angeles Department of Mental Health
550 S. Vermont Ave., Los Angeles, CA 90020, Attn Training Division