New Update

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| --- | --- |
| Client Name: | Case Number: |
| Review Date: | Unit/SubUnit: |

**Provided by External Provider**  Yes  No

If Yes, Diagnosing Clinician (First, Last Name):       Credential:

**Comments:** (Include Rule outs, reason for Diagnosis changes and any other significant information)

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**DIAGNOSIS:** List the appropriate diagnoses. Record as many coexisting mental disorders, general medical conditions, and other factors as are relevant to the care and treatment of the individual.

The Primary Diagnosis should be listed first as priority 1.

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| **ID (ICD-10)** | **Description** | **Priority** | **Begin Date** | **End Date** |
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**CSI General Medical Condition: (Select all that apply)**

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| 00-No General Medical Condition  17-Allergies  16-Anemia  01-Arterial Sclerotic Disease  19-Arthritis  35-Asthma  06-BirthDefects  23-Blind/Visually Impaired  22-Cancer  20-Carpal Tunnel Syndrome  24-Chronic Pain  11-Cirrhosis  07-Cystic Fibrosis | 25-Deaf/Hearing Impaired  12-Diabetes  09-Digestive Disorders  34-Ear Infections  26-Epilepsy/Seizures  02-Heart Disease  18-Hepatitis  03-Hypercholesterolemia  04-Hyperlipidemia  05-Hypertension  14-Hyperthyroid  13-Infertility  27-Migraines | 28-Multiple Sclerosis  29-Muscular Dystrophy  15-Obesity  21-Osteoporosis  37-Other  30-Parkinson’s Disease  31-Physical Disability  08-Psoriasis  36-Sexually Transmitted Disease  32-Stroke  33-Tinnitus  10-Ulcers  99-Unknown/Not Reported |

**Experienced Trauma:**  Yes  No  Unknown/Not Reported

**Signature of Clinician Requiring Co-signature:**

Date:

Signature

Printed Name       CCBH ID number:

**Signature of Clinician Completing/Accepting the Assessment:**

Date:

Signature

Printed Name       CCBH ID number:

**Signature of Staff Entering Information (if different from above):**

Date:

Signature

Printed Name       CCBH ID number: