G.A. FAMILY SERVICES
FOSTER CARE

Mental Health Care Provider Visit Record

Date of Visit: _____

Name of Child: (Last, First, MI)	Date of Birth: / /
Name of Foster Family:	
Name of Provider:	
Provider Address:	
Type of Visit:	**Please Check the Appropriate Box:** □ Initial Assessment □ Crisis Intervention □ Initial Psychiatric Evaluation □ Initial Psychological Evaluation □ Individual Therapy □ Group Therapy □ Family Therapy □ Drug and Alcohol □ Reassessment/Follow-up Psychiatric Evaluation □ Reassessment/Follow-up Psychological Evaluation □ Medication Management □ Other_____
Current Diagnosis:	
Treatment Recommendations:	
Medications/Dosage: (if applicable)	
Medication Change-Date/Reason for Change: (if applicable)	
Follow Up Appointment:	□ None Needed □ Date: Time: **AM/PM**

Provider Signature

Print Name: _____

Signature: _____

Adult Attending with Youth Signature

Print Name: _____Role:_____

Signature: _____

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