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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