TREATMENT UTILIZATION REPORT

___ **Medical** ___ **Dental** ___ **Vision** ___ **Psychiatric**

Client/Patient: ______________________ Date: ______________

Medicaid # ______________________ Caseworker: ______________

Reason for Referral/Symptoms:

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Current Medications:

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Medication Prescribed/Changed:

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Procedures Completed:

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Diagnosis:

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Recommended follow up:

TREATMENT PROVIDER: ______________________ PHONE: ______________

Address: ______________________________________

______________________________ ______________

Treatment Provider's Signature Date

LCHS 3502 (11/07)

LARIMER COUNTY
COMMITTED TO EXCELLENCE

DEPARTMENT OF HUMAN SERVICES
Children, Youth & Family Division
2555 Midpoint Drive, Suite E
Fort Collins, CO 80525
(970) 498-6900 Fax (970) 498-6966