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

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