KAS Service Encounter Form/ Summary Documentation

Provider Name: ______________________  Participant Name: ______________________

Date of Service: _________________  Start Time: _______________  End Time: ____________

Were any health/safety risk factors assessed in this session? ______Yes     ________No

If yes, specify risk factors (e.g., suicidal ideation, homicidal ideation, psychotic symptoms):

**Goals/ Objectives Addressed In This Session:**

**Goal Data (subjective/objective/reported) from session:**

**Interventions used, clinical assessment, progress assessment:**

**Plan for Follow-Up/Summary of Clinical Needs:**

Provider Signature  ____________________________________________    Date ________________

Participant Signature ____________________________________________    Date ________________

(Participant may sign above or on a separate encounter form)