KEYSTONE
AUTISM SERVICES

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)