

MENTAL HEALTH PROGRESS REPORT

I, _____, request that the following information be released to
_____ Assisted Living Facility.

Signature: _____ Date: _____

NAME OF MENTAL HEALTH SERVICE PROVIDER: _____

ADDRESS: _____ TELEPHONE # _____

NAME OF RESIDENT: _____

RESIDING IN: _____

- 1. The person named above does () does not () need continued mental health services.
- 2. Recommendations for continued services: _____

- 3. From a mental health perspective, the needs of this resident can () cannot () continue to be met in an assisted living facility. If "cannot" is marked, please explain:

- 4. It is recommended that the following services be provided by the assisted living facility:

Signature: _____ Title: _____

Date: _____