RED MOUNTAIN
FAMILY SERVICES, INC.

Treatment Foster Parent Progress Note

Child's Name: _____ Date: _____

Date of Birth _____ SS# _____

Please check "yes" or "no" as appropriate. If "yes" was answered, you must document below and notify your Treatment Coordinator during working hours. If after hours, notify RMFS on-call staff, at (505) 362-6186.

Threats of self-harm	___yes	___no	Incidents of self-harm	___yes	___no
Incidents of harm to others	___yes	___no	Substance abuse	___yes	___no
Runaway	___yes	___no	Medical emergency	___yes	___no
Law enforcement involvement	___yes	___no	School involvement	___yes	___no
Emergency Intervention	___yes	___no			

_____

_____

Treatment Goal #1

Objective A:

Objective B:

Objective C:

Treatment Goal #1

Objective A:

Objective B:

Objective C:

Progress Made: _____

_____

_____

_____

_____

_____

Intervention(s) _____

_____

_____

_____

_____

_____

Day and time of therapy (please state what type of therapy) _____

Was there a bio family visit? (Please state what type of visit, who was present, where) _____

_____

Did TFP make contact with the School, Treatment Team members (GAL, CYFD, Insurance), or RMFS Staff (On-Call, TC)?

(Please state who and what type of contact I.e. phone, home visit etc.) _____

_____

Document medication appointment, or appointment with Physician: (Please provide time and prescribing physician name): _____

_____

Any New behaviors that were exhibited today: _____

_____

_____

_____

_____

_____

TFC Parent's Signature Date

_____

Treatment Coordinator's Signature: Date

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