North Carolina Department of Health and Human Services
Adult Services
Interim or Quarterly Client Review

Client Name:	**Date:**
Case #	**ID #**

Review was conducted: (**Check all that apply**):

☐ Adult Day Care Center
☐ In client's home
☐ At DSS
☐ In client's relative's home
☐ By telephone
☐ At nursing home/domiciliary care
☐ Hospital
☐ *Other – please explain below

*

Information was obtained during the review period from: **(Check all that apply**).

☐ Client
☐ Facility staff
☐ Primary caregivers
☐ Aide/paid assistant
☐ Friends
☐ Family
☐ Guardian
☐ *Other professionals

If other, please explain:

Have there been any changes/events since the last review which have had a **SUBSTANTIAL** impact on the client's/family's life or need for services? If yes, summarize briefly below.

Update face sheet to reflect any changes such as address, telephone, or household composition.

Review of the functional domains

Please include in your summary new problems, worsening conditions, improvements, and new resources or accomplishments. (*Include information that documents the continuing need for services*.)

Social

Environmental (home and neighborhood)

Economic

Mental/Emotional Health

ADLs and IADLs

Physical Health

Summarize below any other significant events, contacts, or activities during the quarter (include dates) or attach relevant sections of your log notes.

Update service plan as needed and during each quarterly review with progress toward each goal and add new goals *The service plan form (include form number and name) should be updated as needed.*

Social Worker's Signature

Click or tap to enter a date.
Date