DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Mental Health and Substance Abuse Services
F-21168 (08/2008)

CASE-FOCUSED CASE MANAGEMENT EDUCATION

Completion of this form is voluntary. The information is being collected as part of a pilot project being conducted by the Bureau of Mental Health and Substance Abuse Services of the Department of Health Services and the Mental Health and Education Resource Center at the University of Wisconsin-Madison to provide a case-focused continuing education program for Wisconsin mental health professionals.

PERSONAL INFORMATION

Name – Participant (Last)	(First)	(MI)

Your name as you would like it to appear on the CME/CEU Certificate (if different than above)

Contact Address (Street)	Apt. / Unit #	City	State	Zip Code
			WI	

Telephone Number – Home	Telephone Number – Alternate	Title / Medical Specialty
( )	( )	

E-mail Address

Please share comments or concerns about your continuing education needs, history, and preferences

EMPLOYER INFORMATION (Optional)

Name – Employer

Department

Contact Address (Street)	City	State	Zip Code
		WI	

Telephone Number – Work	Fax Number	Employer Webpage URL
( )	( )	

Specialty Licensure/Credentials Earned

OTHER PROFESSIONALS ACTIVELY WORKING WITH CHILD / ADOLESCENT (Please check all that apply)

- ☐ School Psychologists—how many? __________
- ☐ Clinical Psychologists—how many? __________
- ☐ Counseling Psychologists—how many? __________
- ☐ Rehabilitation Psychologists—how many? __________
- ☐ Licensed Foster Parents—how many? __________
- ☐ Social Workers—how many? __________
- ☐ Other Caseworkers—how many? __________
- ☐ Behavioral Neurologists—how many? __________
- ☐ Pediatricians—how many? __________
- ☐ Psychiatrists—how many? __________
- ☐ Judges—how many? __________
- ☐ Attorneys—how many? __________
- ☐ Pastor / Rabbi—how many? __________
- ☐ Other Counselors—how many? __________
- ☐ Other Mental Health Professionals—how many? __________ Please describe

- ☐ Other Professionals—how many? __________ Please describe

CHILD / ADOLESCENT CASE INFORMATION (NOTE: Please do not include any personally identifiable patient information)

Current Primary Diagnosis (If no formal diagnosis, provide working diagnosis and/or detail below)

☐ Male ☐ Female

Age ____ years old

Concurrent Comorbid Diagnoses

Current Medications and Dosing Information

Drug (Brand)	Dosage/Administration

Active Symptoms and Concerns

☐ Yes ☐ No Current or past history of substance abuse/misuse?

☐ Yes ☐ No Current or past history of juvenile justice involvement?

☐ Yes ☐ No Are you willing to provide case records with personally identifiable information redacted?

For Office Use: