Amerigroup RealSolutions® in healthcare

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Behavioral Health Progress form

Please complete and return to care coordinator within seven business days of member visit.

Member name:	**Date of birth:**
Agency/office:	

Therapist name	**Appointment type (seven-day, routine, assessment, etc.)**	**Date of appointment**

Medication name, dosage and schedule:

Compliant with medication: **Yes** ☐ **No** ☐

☐ **Other medications (e.g., over-the-counter, supplements, etc.):**

Client report:

Client progress since last visit:

Provider narrative/comments/follow-up plan: