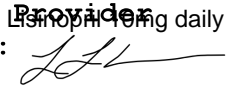


INITIAL CONTACT REPORT

COMMUNITY TREATMENT SERVICES

FEDERAL BUREAU OF PRISONS
U.S. DEPARTMENT OF JUSTICE

John Doe		1980-05-15	Male
This documents and notifies Community Treatment Services staff of initial face-to-face contact with the inmate. john.doe@example.com			
TREATMENT PROVIDER/AGENCY: Transitional Care Management, LLP Dallas Address: 15400 Knoll Trail Drive TX 75201 City/State/Zip: Dallas, TX Jane Doe Telephone: 737-242-6826 (555) 987-6543 Fax: 512-872-5336			
INMATE NAME: Blue Cross Blue Shield REG. NO.:		DATE OF INITIAL CONTACT: ABC123456789	
2025-12-01 10:00 AM Initial Consultation If the contact was made more than ten (10) calendar days after the date treatment was authorized to begin on the referral form, please detail below the reason.			
Dr. Sarah Smith REASON INITIAL CONTACT IS LATE: Persistent headaches and difficulty sleeping Patient reports recurring headaches over the past 3 months, primarily in the evening. Also experiencing difficulty falling asleep.			
Was the BP-A0528 Authorization for Release of Information (ROI) form completed prior to or during the initial contact? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Was the BP-A0750 Agreement to Participate in Community Treatment (Informed Consent) form completed during the initial contact? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Hypertension (controlled), No known allergies			
Were the completed ROI and Informed Consent forms forwarded to Community Treatment Services Staff with this Initial Contact? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Treatment Provider Signature:  PRINT Name: Lauren Herraiz		Date: _____	

2025-12-01