

## MONTHLY TREATMENT REPORT

This form must be completed and submitted with each monthly billing. Additional sheets may be used.

1. PROGRAM NAME:		1a. PROVIDER NAME:		2. DATE OF CURRENT TX PLAN (ATTACH REVISIONS):	
3. CLIENT NAME:		3a. PACTS NO.	4. FOR PERIOD COVERING:		
5. PHASE NO.	5a. TIME IN PHASE:	6. PRETRIAL CLIENT: <input type="checkbox"/> Yes <input type="checkbox"/> No		7. CLIENT EMPLOYED: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Student <input type="checkbox"/> Other	

### 8. CONTACTS SINCE LAST REPORT

a. Date	b. Service (Name & No.)	c. Length of Contact	d. Comments (No Shows, Tardiness, Issues Addressed)	e. Copay (amount collected)

### 9. URINE TESTING RECORD

DATE COLLECTED	Scheduled		Sample Not Tested		Drug Use Admitted		COLLECTED BY	SPECIAL TESTS REQUESTED	TEST RESULTS (Positive/Negative)	Copay (amount collected)
	Yes	No	Insuf. Qty.	Stall	No	Yes (specify drug)				

### 10. COMMENTS REGARDING CLIENT'S TREATMENT PROGRESS

a. Describe the treatment goals addressed this month ( Met    Not Met):

b. Describe any steps taken by the client this month toward these goals ( Positive    Negative):

c. Describe any obstacles or setbacks the client encountered this month:

d. Describe one unique way the PO/PSO can assist/support the client in treatment over the next month:

e. If continued treatment is recommended, discuss the plan for next month ( Recommended    Not Recommended):

f. Discuss your observations of the client's behavior and commitment to treatment ( Positive    Negative):

g. Comments:

h. Overall Progress:    Acceptable    Unacceptable

SIGNATURE OF COUNSELOR	DATE
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