



NURSE THERAPIST REPORT

Peer Assistance Services

Client Name: _____ Contract Received? Yes No

From (date) : _____ To (date) : _____

State the number and frequency of visits: _____

Has the client complied with visits on dates scheduled? Yes No

If not, please explain in detail (i.e., was it a scheduling problem, what type, was it rescheduled):

Is the client engaged in treatment? Yes No

Progress: _____

Assessment of mental status: _____

*It is my opinion that the above named client does **not** have a mental or physical disability which renders him/her unstable to practice in the licensed profession with reasonable skill and safety.*

Agree Disagree

If disagree, please explain: _____

Document any evidence of drug or other substance use: _____

Additional comments: _____

Signature

Title

Date

Name/Credentials (Please Print)

Facility/Agency

Address:

Reports are due by the _____ of each month.
See web site for due dates.

Phone:

Mail or Fax Original To:

Metro Denver, Northern and Southern:
Peer Assistance Services, Inc.
2170 S. Parker Road, Suite 229
Denver, CO 80231
Phone: 303.369.0039 or 866.369.0039
Fax: 720.213.1007

Western Slope Clients Only:
Peer Assistance Services, Inc.
200 Grand Avenue, Suite 260
Grand Junction, CO 81501
Phone: 970.986.4360
Fax: 970.241.9094