



Psychiatrist /Addictionologist /RxN Report

Client Name: _____ Monthly/Quarterly Report from: _____ to _____
mo/day/yr mo/day/yr

Number of visits during this reporting period: _____ Frequency of visits: _____

Has the client complied with visits and treatment as scheduled? _____ Yes _____ No

If not, were the absences excused or unexcused? _____ # Excused _____ # Unexcused

Other reasons: _____

List current DSM-IV-TR diagnoses: _____ Current GAF: _____

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

List the current medications you are prescribing for this client:

Medication	Dosage	Frequency	Reason for Rx

Has the client complied with the medication regimen? _____ Yes _____ No

List the issues that the client has addressed in the reporting period: _____

Do you have any concerns about your client's ability in the practice setting to: (check any that apply)?

- _____ Problem solve
- _____ Make critical decisions
- _____ Cope appropriately with stressful situations

If so, please explain: _____

It is my opinion that the client is able to practice with reasonable skill and safety. _____ AGREE _____ DISAGREE

If you disagree, please explain: _____

Document any evidence of drug or substance use during this reporting period: _____

Additional comments/plans for changes to treatment plan: _____

Signature _____

Printed Name/Credentials _____

Date _____

Phone: _____

Fax: _____

Address _____

This report is due by the _____ of each month. (See web site for due dates.)

Mail or Fax Original To:
Metro Denver, Northern and Southern:
Peer Assistance Services, Inc. Peer
2170 S. Parker Road, Suite 229
Denver, CO 80231
Phone: 303.369.0039 or 866.369.0039
Fax: 720.213.1007 or 720.213.0002

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