



THERAPIST REPORT

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: _____

Assessment of alcohol and/or substance use: _____

Do you have any concerns about the licensee's ability to perform the following tasks in the work place:

- Think critically, plan, organize, and prioritize. Yes No
- Remember and concentrate. Yes No
- Communicate effectively with health care team members. Yes No
- Develop and maintain a therapeutic provider-patient relationship. Yes No
- Respond appropriately to an emergency in the work place. Yes No

If "yes," please explain _____

The above named client does **not** have a physical, emotional, or psychological problem which renders him/her unstable to practice in the licensed profession with reasonable skill and safety.

Agree Disagree

The above named client does **not** exhibit addictive behavior and/or patterns of behavior which may impair his/her ability to practice in the licensed profession with reasonable skill and safety.

Agree Disagree

If disagree, please explain _____

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 NURSE Clients Only:

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