



TREATMENT PROVIDER REPORT

Client Name: _____ Contract Received: Yes No

Reporting Period: From (date): _____ To (date): _____

Please indicate the level of treatment the client is participating in:

Residential IOP Outpatient Continuing Care Other _____

If on an outpatient basis, 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 Please describe clients progress:

To your knowledge, has client remained abstinent from alcohol and other drugs: Yes No Please explain:

Assessment of mental status:

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:

Additional comments:

Signature Title Date

Name/Credentials (Please Print) Facility/Agency

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-Mail: _____

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 or 720.213.0002

Western Slope NURSE Clients Only:

Peer Assistance Services, Inc.
200 Grand Avenue, Suite 260
Grand Junction, CO 81501
Phone: 970.986.4360
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