Peer Assistance Services

TREATMENT PROVIDER REPORT

Client Name: _____ Contract Received: ❒ Yes ❒ No

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

Please indicate the level of treatment the client is participating in: ***(Circle One)***

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

Progress: _____

_____

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

If not, 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: _____ 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
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Fax: 720.213.1007

Western Slope NURSE Clients Only:

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