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| PROB. 46(Rev. 06/10)**MONTHLY TREATMENT REPORT** | This form must be completed and submitted with each monthly billing. Additional sheets may be used. |
| 1. PROGRAM NAME: | 1a. PROVIDER NAME: | 2. DATE OF CURRENT TX PLAN (ATTACH REVISIONS) |
|  |  |  |
| 3. CLIENT NAME: | 3a. PACTS NO.  | 4. FOR PERIOD COVERING |
|  |  |  |
| 5. PHASE NO.  | 5a. TIME IN PHASE:  | 6. PRETRIAL CLIENT: | 7. CLIENT EMPLOYED: |
|  |  | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No [ ]  Student [ ]  Other |
| **8. CONTACTS SINCE LAST REPORT** |
| a. Date | b. Service (Name & No.) | c. Length of contact | d. Comments (No Shows, Tardiness, Issues Addressed) | e. Copay (amount collected) |
|  |  |  |  |  |
| **9. URINE TESTING RECORD** |
| DATE COLLECTED | Scheduled | Sample Not Tested | Drug Use Admitted | COLLECTED BY | SPECIAL TESTS REQUIRED | TEST RESULTS (Positive/Negative) | Copay (amount collected) |
| Yes | No | Insuf. Qty. | Stall | No | Yes (Specify drugs) |
|  |  |  |  |  |  |  |  |  |  |  |
| **10. COMMENTS REGARDING CLIENT’S TREATMENT PROGRESS** |
| a. Describe the treatment goals addressed this month ([ ]  Met [ ]  Not Met): |
|  |
| b. Describe any steps taken by the client this month toward these goals ([ ]  Positive [ ]  Negative): |
|  |
| c. Describe any obstacles or setbacks the client encountered this month: |
|  |
| d. Describe one unique way the PO/PSO can assist/support the client in treatment over the next month: |
|  |
| e. If continued treatment is recommended, discuss the plan for next month ([ ]  Recommended [ ]  Not Recommended): |
|  |
| f. Discuss your observations of the client’s behavior and commitment to treatment ([ ]  Positive [ ]  Negative): |
|  |
| g. Comments |
|  |
| h. Overall Progress: [ ]  Acceptable [ ]  Unacceptable |
| SIGNATURE OF COUNSELOR | DATE |