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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 | | | | | | |