



Psychiatrist /Addictionologist /RxN Report

Client Name: _____ Monthly/Quarterly Report from: _____ to _____
mo/day/yr mo/day/yr

Number of visits during this reporting period: _____ Frequency of visits: _____

Has the client complied with visits and treatment as scheduled? Yes No

If not, were the absences excused or unexcused? _____ # Excused _____ # Unexcused

Other reasons: _____

List current DSM-IV-TR diagnoses: _____ Current GAF: _____

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

List the current medications you are prescribing for this client:

Medication	Dosage	Frequency	Reason for Rx

Has the client complied with the medication regimen? Yes No

List the issues that the client has addressed in the reporting period:

Do you have any concerns about your client's ability in the practice setting to: (check any that apply)?

- Problem solve
- Make critical decisions
- Cope appropriately with stressful situations

If so, please explain:

It is my opinion that the client is able to practice with reasonable skill and safety. AGREE DISAGREE

If you disagree, please explain:

Document any evidence of drug or substance use during this reporting period:

Additional comments/plans for changes to treatment plan:

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

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200 Grand Avenue, Suite 260
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