



THERAPIST REPORT

Client Name: _____ Contract Received: Yes No

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

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:

Assessment of mental status:

Assessment of alcohol and/or substance use:

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:

The above named client does not have a physical, emotional, or psychological problem which renders him/her unstable to practice in the licensed profession with reasonable skill and safety.

Agree Disagree

The above named client does not exhibit addictive behavior and/or patterns of behavior which may impair his/her ability to practice in the licensed profession with reasonable skill and safety.

Agree Disagree

If disagree, 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 Fax: 970.241.9094