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 REQUESTED	TEST RESULTS (Positive/Negative)	Copay (amount collected)
	Yes	No	Insuf. Qty.	Stall	No	Yes (specify drug)				

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

DISTRIBUTION: ☐ ORIGINAL ☐ CONTRACTOR