PROB 46 (Rev. 10/30)

# 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: ☐ Yes ☐ No | 7. CLIENT EMPLOYED: ☐ 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) |
|---|---|---|---|---|
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## 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): Criminogenic Needs

b. Describe any steps taken by the client this month toward these goals (☐ Positive ☐ Negative):

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| c. Describe any obstacles or setbacks the client encountered this month: |
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| |
| d. Describe one unique way the PO/PSO can assist/support the client in treatment over the next month: |
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| 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. Risk of danger to self or others: |
| |
| h. Overall Progress: ☐ Acceptable ☐ Unacceptable |

| SIGNATURE OF COUNSELOR | DATE | APPROVAL SIGNATURE | DATE |
|---|---|---|---|
| | | | |

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