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:	2. OFFICER 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)
			CO-PAY BALANCE	

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