THERAPIST/COUNSELOR REPORT

Report Due: Monthly for the first 6 months of full compliance and then quarterly thereafter.

DOPL
ATTN: COMPLIANCE UNIT
PO BOX 146741
SALT LAKE CITY UT 84114-6741

Case #:
Name of Licensee:
Profession
Dates Seen:
Length of Sessions:

Were there any missed appointments?
D No D Yes How many?

Questions? Call 530-6428, 530-6718 or 530-6295

Have you read the conditions of licensee’s Contract/Order? D Yes D No. If No, please read it before submitting this document.

Diagnosis (DSM-5)

Please list current medications:

What are the major issues being addressed in therapy?

Please list the goals of treatment:

Please comment in detail on how the licensee is doing with regard to relevant issues. Include at least the following: recognition and insight into problems, interaction during sessions, ability to solve problems and compliance with recommendations.

Evaluation of Progress

Is Licensee in Compliance with Treatment Plan? D Yes D No

In your opinion, is Licensee safe to Practice? D Yes D No

Name (Please Print)

Signature of Therapist

Title (Please Print)

Signature Date

DOLP-FM-055 Rev 3/11/2008 This document may be submitted by FAX to (801) 530-6404.