

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?

No Yes How many? _____

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

Have you read the conditions of licensee's Contract/Order? Yes 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? Yes No

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

Name (Please Print)

Signature of Therapist

Title (Please Print)

____/____/____
Signature Date