|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Offender # | Individual’s Name: | | | | | | | | | | | | Date: |
| Click to enter text. | Click to enter text. | | | | | | | | | | | | Click to enter a date. |
| Supervising Agent: | | | Email: | | | | | | | Telephone: | | | |
| Click to enter text. | | | Click to enter text. | | | | | | | Click to enter text. | | | |
| Supervisor: | | | Email: | | | | | | | Telephone: | | | |
| Click to enter text. | | | Click to enter text. | | | | | | | Click to enter text. | | | |
|  | | | | | | | | | | | | | |
| Date of Report: | | Click to enter a date. | | | | | Admit Date: | | | | Click to enter a date. | | |
| (RESIDENTIAL ONLY) Projected Discharge Date: | | | | | | | | Click enter a date. | | | | | |
| During the month of Click to enter a date. the offender has/had the following appointments: | | | | | | | | | | | | | |
| INDIVIDUAL THERAPY | | | | | | | PEER RECOVERY COACH | | | | | | |
| CASE MANAGEMENT | | | | | | | GROUP | | | | | | |
| PSYCHIATRIST | | | | | | | OTHER (Primary Care visit, MAT Provider, Specialist, etc.) | | | | | | |
| IF OTHER SELECTED PLEASE EXPLAIN: | | | | | | | Click or tap here to enter text. | | | | | | |
| The individual cancelled appointments on: | | | | | | | Click to enter a date., Click to enter a date., Click to enter a date., | | | | | | |
| The individual missed appointments on: | | | | | | | Click to enter a date., Click to enter a date., Click to enter a date., | | | | | | |
| The provider cancelled appointments on: | | | | | | | Click to enter a date., Click to enter a date., Click to enter a date., | | | | | | |
| The individual has participated: | | | |  | Not at all  Minimally  Fluctuates between participation and not participating  Consistently participating | | | | | | | | |
| The individual has been drug tested: | | | | Date: | | Click to enter a date. | | | Results: | | | Choose an item. | |
| Date: | | Click to enter a date. | | | Results: | | | Choose an item. | |

|  |  |  |  |
| --- | --- | --- | --- |
| Progress during treatment. Discuss treatment plan, progress towards goals, things they are doing well with, things they are struggling with and any suggested treatment recommendations: | | | |
|  | | | |
| Any changes of Medications associated with Medication Assisted Treatment: | | | |
|  | | | |
| Providers Name: | Click to enter text. | Email: | Click to enter text. |
| Phone Number: | Click to enter text. |  | |