

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935

FAX #: (608) 266-2264
Phone #: (608) 267-3817

1400 E. Washington Avenue
Madison, WI 53703

E-Mail: web@dsps.wi.gov
Website: <http://dsps.wi.gov>

MONITORING

THERAPY REPORT FORM

If you have any questions regarding this report, please contact the Monitor at 608-267-3817.
Please provide as much detail as possible (use back of page or additional sheets, if necessary).

Patient/Client's name: _____

Inpatient treatment? _____ Outpatient treatment? _____

Does treatment consist of individual sessions? _____

Does treatment consist of group sessions? _____

Type of Group: _____ Facilitator: _____

Dates of sessions in the last 3 months:

Please discuss client's progress in treatment over the past 3 months:

Please discuss treatment plans for the next 3 months:

Are you recommending any modifications to the Order? () Yes () No If yes, please specify:

Do you feel this client is able to competently practice in his/her professions? () Yes () No

If no, please explain:

Prognosis?

Please describe difficulties encountered in providing services for this client to meet the requirements to maintain their license:

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If client has an alcohol/drug impairment, please answer these additional questions:

Please discuss acceptance of addictive disease and his/her willingness to acknowledge and accept the consequences of the disease:

Please discuss concerns you have regarding this client's recovery:

To the best of your knowledge, is this client remaining abstinent? Yes No If No, please describe the relapse.

To the best of your knowledge, is this client having difficulty in remaining abstinent?

Number of AA/NA or self help meetings client attends per week? _____

To the best of your knowledge, is this client in compliance with his/her Board's order? Yes No
If no, please explain: _____

Please attach any drug screen results that you may have for this client.

Signature of Therapist

Date

Print name of Therapist and Title

Therapist's License Number

Name and address of treatment facility

() _____
Phone number

Please feel free to attach any additional information you wish to bring to the Monitor's attention.

Please mail or fax this form every three months to:

**ATTN: Department Monitor
Wisconsin Department of Regulation & Licensing
PO Box 8935
Madison, WI 53708-8935
Fax (608) 266-2264**