

Louisiana State Board of Nursing

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<http://www.lsbns.state.la.us>

Therapist/Counselor Report Form

A. Participant: _____

B. Treating Clinician: _____

a. Address: _____

b. Phone: () _____ Fax: () _____

C. Reporting Period: _____

(Indicate month or months client was seen)

D. Treatment issues addressed: _____

Provide a brief comment regarding the progress made in treatment toward these issues (or the lack thereof) and any concerns: _____

E. Number of sessions scheduled: _____ Number of sessions attended: _____

Reason(s) for missed sessions: _____

F. Frequency of sessions: _____ (weekly, monthly, quarterly, etc)

G. Next scheduled session: _____

H. AA/NA attendance reported: Y N N/A

I. Any known alcohol or drug use: Y N N/A

J. Compliant with treatment: Y N

K. Anticipated date of completion of treatment: _____

Signature

Date