TREATMENT PROVIDER REPORT

Participant Name: _____

List all dates the above-named individual attended counseling / therapy sessions:

_____

Primary and Secondary Treatment Focus: _____

Medication	Indication	Dosage & Frequency	Number of Refills

Please use the back of this form if you need additional space to list medications.

Participant's current diagnosis: _____

Has there been any change in Participant's diagnosis? If yes, please explain: _____

_____

Participant's treatment plan, recommendations, and interventions: _____

_____

_____

Please submit this form to ArNAP staff by the tenth (10th) of the following months:
☐ Jan ☐ Feb ☐ March ☐ April ☐ May ☐ June ☐ July ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec
Fax: (501)686-2714 ~ Email: Tonya.Gierke@Arkansas.gov

If participant is NOT being treated for Substance Use Disorder, the participant is no longer required to submit this form every three (3) months. Please send documentation to ArNAP staff indicating such.

_____ _____
(Treatment Provider signature) (Print name and title)

_____ _____
(Date) (Address and phone number)