TREATMENT PROVIDER REPORT

Participant Name: ____

List all dates the participant attended counseling / therapy: ____________________

____

Primary and Secondary Treatment Focus: ____________________________

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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: ________________

____

Completed form may be given to the participant for submission to the Board. Upon completion of treatment (discharge), please send documentation to ArNAP staff indicating such. Once treatment is completed, this form is no longer required to be submitted.

____________________ ____________________________

(Treatment Provider signature) (Print name and title / Facility Name)

____________________ ____________________________

(Date) (Address and phone number)

Revised: Feb. 2022