



LOUISIANA

STATE BOARD OF SOCIAL WORK EXAMINERS

IMPAIRED PROFESSIONAL PROGRAM

Psychiatrist /Addictionologist Report Form

A. Participant: _____

B. Treating Physician: _____

a. Address: _____

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

C. Reporting Period: _____

(Indicate month or months client was seen)

D. Diagnosis or reason for visit: _____

E. Provide a brief comment regarding the progress made in treatment (or the lack thereof): _____

F. Current medication or change in medication: _____

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

Next scheduled session: _____

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

I. Reason(s) for missed sessions: _____

J. Provided copy of Consent Order and/or Participation Agreement? Y N

K. Provided copy of Evaluation/Discharge Summary from primary provider? Y N

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

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

N. Compliant with treatment: Y N

O. Anticipated date of completion of treatment: _____

Signature

Date

Please mail original to:

18550 Highland Road, Suite B, Baton Rouge, LA 70809

Telephone: (225) 756-3470, <http://www.labswe.org>