LOUISIANA
STATE BOARD OF SOCIAL WORK EXAMINERS
IMPAIRED PROFESSIONAL PROGRAM

Therapist 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 (as identified in Participation Agreement):

_____

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. Provided copy of Consent Order and/or Participation Agreement? Y N
I. Provided copy of Evaluation/Discharge Summary from primary provider? Y N
J. AA/NA attendance reported: Y N N/A
K. Any known alcohol or drug use: Y N N/A
L. Compliant with treatment: Y N
M. 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