Healthcare Professionals' Foundation of Louisiana

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TREATING PROFESSIONAL MONTHLY REPORT FORM

A. HPFL Participant: ____

B. Treating Professional: ____

Address: ____

Phone: ______________________ Fax: ___________________ Email: ________________________

C. Reporting Period: ____
(Month)

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

____
____
____
____
____

E. Write the **number** of sessions **attended** in the appropriate blank(s) below:

[IOP____] [Aftercare____] [Other group____] [Individual____] [Family____][Med. Management____]

F. Write the **number** of sessions **required** in the appropriate blank(s) below:

[IOP____] [Aftercare____] [Other group____] [Individual____] [Family____][Med. Management____]

G. Reasons for missed sessions: ____
____
____
____

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