THERAPIST REPORT

Report due monthly unless otherwise instructed.

Case # required.

This document can be uploaded to Spectrum or;
submitted by FAX at: 801-530-6404

Case # *(found on Stipulation):* _____

Name of Licensee: _____

Profession: _____

Dates seen: _____

Length of sessions: _____

Appointments missed? ◯ YES ◯ NO
If yes, how many?_____

Have you been provided a copy of the licensee's Stipulation or memorandum of Understanding and have you reviewed the conditions therein? ◯ YES **If not, please do so prior to submitting this document.**

Diagnosis(DSM-4 Axis I-V): _____

List current medications: _____
_____

What are the major issues being address in this therapy? _____
_____

List the goals of this treatment: _____
_____

Comment here, in detail on how the licensee is doing with regard to relevant issues. Include the following; recognition and insight into issues, interaction during sessions, ability to problem solve, and compliance with recommendations: _____
_____
_____
_____

Licensee compliant with treatment plan? ◯ YES ◯ NO

In your opinion, is licensee safe to practice their profession? ◯ YES ◯ NO

_____ _____
Name *(print)* Signature

_____ _____
Title Today's Date