PROB 46 (Rev. 06/10) MONTHLY TREATMENT REPORT								This form must be completed and submitted with each monthly billing. Additional sheets may be used.			
1. PROGRAM NAME:   1a. PROVIDER								2. DATE OF CURRI	ENT TX PLAN (ATTACH I	REVISIONS):	
3. CLIENT NAME:						CTS NO.	4. FOR PERIOD COVERING:				
5. PHASE NO. 5a. TIME IN PHASE: 6. PRETRIA						RIAL CLIENT: 7. CLIENT E		APLOYED:			
□ Yes □ No							$\square$ Yes $\square$ No $\square$ Student $\square$ Other				
					8. C	ONTACTS SIN	CE LAST RE	PORT			
a. Date	b. S	b. Service (Name & No.)				ength of Contact	d. Comments (No Shows, Tardiness, Issues Addressed)			e. Copay (amount collected)	
9. URINE TESTING RECORD											
DATE		Scheduled Sample Not Tested			d Di	rug Use Admitted	COLLECTED	SPECIAL TESTS	TEST RESULTS	Copay (amount collected)	
COLLECTED	Yes	No	Insuf. Qty.	Stall	No	Yes (specify drug)	BY	REQUESTED	(Positive/Negative)	collected)	
10. COMMENTS DECADDING CLIENT'S THEATMENT BROCHESS											
10. COMMENTS REGARDING CLIENT'S TREATMENT PROGRESS       a. Describe the treatment goals addressed this month (											
a. Sesence de doublent gouis dedressed uns month (= inter = not inter).											
b. Describe a	ny steps	taken	by the clie	nt this n	nonth tov	ward these goals (	Positive D	Negative):			
c. Describe a	ny obsta	cles of	r setbacks t	he clien	t encoun	tered this month:					
d. Describe c	ne uniqu	ie way	the PO/PS	SO can a	ssist/sup	port the client in tr	eatment over th	e next month:			
a If continue	e. If continued treatment is recommended, discuss the plan for next month ( Recommended  Not Recommended):										
e. Il continue	u iieaiii		recomment	ueu, uist	cuss the p			ided <u>i</u> Not Keet	ininended).		
f. Discuss yo	ur obser	vation	s of the clie	ent's bel	navior an	d commitment to t	reatment ( Po	sitive 🗖 Negative	e):		
g. Comments	:										
h. Overall Pr	ourees.		cceptable		accentabl	e					
SIGNATURE C				<u> </u>				DATE			