✎PROB 46
(1/86)

MONTHLY TREATMENT REPORT

This form must be completed and submitted with each monthly billing. Additional sheets may be used.

1. PROGRAM	2. CONTRACT NUMBER	2a. FUND CONTROL NO.

3. CLIENT	4. FOR PERIOD COVERING

5. PHASE	5a. TIME IN PHASE	6. PRETRIAL CLIENT	7. CLIENT EMPLOYED:
		☐ Yes ☐ No	☐ Yes ☐ No ☐ Student ☐ Other

8. CONTACTS SINCE LAST REPORT

a. Date	b. Service (Name & No.)	c. Length of Contact	d. Comments (Identify all Stalls/No Shows)

9. URINE TESTING RECORD

DATE COLLECTED	Scheduled		Sample Not Tested		Drug Use Admitted		COLLECTED BY	SPECIAL TESTS REQUESTED	TEST RESULTS	Tests Neg.
	Yes	No	Insuf.Qty	Stall	No	Yes(specify dr.)				

10. COMMENTS REGARDING CLIENT'S TREATMENT PROGRESS

SIGNATURE OF COUNSELOR	DATE

DISTRIBUTION: ORIGINAL CONTRACTOR