PROB 46 (7/01)

MONTHLY TREATMENT REPORT

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

1. AGENCY:	2. FOR PERIOD COVERING:	5. DATE OF MOST RECENT PROGRAM PLAN (Form 45):
3. CLIENT NAME:	4. PRETRIAL CLIENT: ☐ YES ☐ NO	

6. CONTACTS SINCE LAST REPORT

a. Date	b. Type of Service:	c. Time in:	d. Time out:	e. Client Signature: (signed at end of service)	f. Copay amount collected:

7. URINE TESTING RECORD

a. Date	b. Collected by:	c. Bar Code #	d. Remarks: (Specimen appeared clear, client stalled, etc.)	e. Client Signature: (Signed after giving urine)	f. Copay amount collected:

8. COMMENTS REGARDING CLIENT'S PROGRESS IN TREATMENT
(attendance, level of participation, problem areas, progress toward goals, etc)

SIGNATURE OF COUNSELOR:	DATE: