HAVEN

Health Assistance InterVention Education Network

HAVEN ID #: ____________
HAVEN Confidential Fax #: 860 828-3192
Individual ☐
Group ☐

QUARTERLY THERAPIST REPORT

Reporting Period: ☐ **January to March – due April 15** ☐ **April to June – due July 15**
☐ **July to September – due Oct. 15** ☐ **October to December – due Jan. 15**

1A. # of Individual Sessions Scheduled: _______ # Attended by Participant: _______ # Missed: _______

1B. # of Group Sessions Scheduled: _______ # Attended by Participant: _______ # Missed: _______

(Please explain missed sessions) ____

2. Has the frequency of therapy sessions been changed in the last quarter, and if so, is this change based on your recommendation?

____

3. Please list the current medications identified in your records/prescribed by you for this professional?

Medication Name	Daily Dose	Medication Name	Daily Dose

4. Since the last report, have you referred this health care professional to any other health care professional for care and treatment? ☐ No ☐ Yes (If yes, please list name of provider and reason for referral)

____

5. Has this health care professional been compliant with treatment and therapy? ☐ Yes ☐ No

6. Participation in sessions: ☐ Active ☐ Neutral ☐ Reluctant ☐ Passive/Resistant ☐ Hostile/Challenge

7. Overall progress rating:
☐ Actively working toward treatment goals
☐ Maintaining status quo since last report
☐ Regression or deterioration since last report (*explain*)

8. From a therapeutic perspective, is this professional able to practice with reasonable skill and safety?
☐ Yes ☐ No

9. Would you like HAVEN to contact you about this participant? ☐ Yes ☐ No

If necessary, please attach an additional page to provide a confidential statement regarding this professional's ability to practice with reasonable skill and safety.

Please note HAVEN's treatment recommendations and/or requirements of compliance:
Continue treatment as long as deemed necessary. Please call HAVEN before considering termination and/or major changes in treatment to discuss. Please notify HAVEN immediately if there are any clinical concerns that would affect the participant's ability to practice with reasonable skill and safety.

Name ______________________ Signature ______________________

Date ______________________

Preferred method of contact ☐Phone: ☐ Fax: ☐ Email: ______________________
(please provide Phone, Fax, or Email)

FORM MAY BE FAXED TO HAVEN AT 860-828-3192

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