PROB 46

MONTHLY TREATMENT REPORT

1. VENDOR:	**4. USPO/USPTSO:**
2. CLIENT:	**5. FOR PERIOD COVERING:**
3. PHASE:	**6. TIME IN PHASE:**

7. CLIENT CONTACTS

a. Date	b. Service	c. Length of Contact	d. Comments

8. URINE TESTING RECORD

DATE COLLECTED	NO SHOW	SAMPLE - NO TEST		DRUG USE ADMITTED (Specify Drug)	COLLECTED BY	SPECIAL TESTS REQUESTED	TEST RESULTS (Specify Drug if Positive)	DATE OF RESULT
		Insuf. Qty.	Stall					

9. COMMENTS REGARDING CLIENT'S TREATMENT PROGRESS

10. CLIENT COPAY

Amount Ordered	
Amount Collected	
Balance (if app.)	
Date of Last Payment	

Date/Signature of Counselor: **(INVOICE MAY NOT BE PAID IF COUNSELOR'S SIGNATURE IS ABSENT)**

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