ARKANSAS MEDICAL FOUNDATION
QUARTERLY PSYCHIATRIST/COUNSELOR REPORTS

PARTICIPANT: _____ DATE: _____

PSYCHIATRIST/COUNSELOR: _____

WAS SEEN TODAY FOR:
_____ ADDICTION COUNSELING/SUPPORT
_____ INDIVIDUAL THERAPY
_____ GROUP THERAPY
_____ MEDICATION MANAGEMENT

RELATED ISSUES ADDRESSED INCLUDE:

_____

_____

_____

_____

_____

_____

_____

CLIENT _____ HAS _____ HAS NOT BEEN PARTICIPATING ACTIVELY, KEPT APPOINTMENTS AND IS PROGRESSING AS EXPECTED.

ADDITIONAL COMMENTS IF NEEDED:

_____

_____

_____

_____

_____

_____

_____

NEXT APPOINTMENT IS SCHEDULED FOR: _____

_____

SIGNATURE OF PSYCHIATRIST/COUNSELOR

REPORTS MUST BE RECEIVED DIRECTLY FROM TREATMENT PROVIDER BY JANUARY 5 TH, APRIL 5 TH, JULY 5™ AND OCTOBER 5 TH AND MAY BE MAILED TO 10 CORPORATE HILL DRIVE, SUITE 150, LITTLE ROCK, AR 72205, FAXED TO 501.224.9966 OR EMAILED TO director@arkmedfoundation.org. THANK YOU.