Chemical Dependency Progress Report

This request is to only be used to request **ADDITIONAL IN/OUTPATIENT CD TREATMENT SERVICES**. If a request is needed for a CD Evaluation or initial notification review for in/outpatient CD treatment, please use the "**Notification Review for Chemical Dependency Evaluation**" or " **Notification Review for New In/Outpatient Chemical Dependency Services**" forms, which can be found at www.team-mn.com.

Please print clearly. Incomplete or illegible forms can not be processed.

Client and Provider Information

Client's Name	**Facility Name & Address**
Client's Address	**Admission Date**
Client's Date of Birth	**Program (inpatient, outpatient, relapse, aftercare)**
Today's Date	**Clinician's Name**
Expected Discharge Date	**Clinician's Phone & Fax#**

Clinical Progress

For (MAT) medical assisted therapy, please list medication/dosage:

Client's attendance is satisfactory: Yes ☐ No ☐ Comments:

Client is engaged in treatment process: Yes ☐ No ☐ Comments:

Client is maintaining abstinence: Yes ☐ No ☐ Comments:

Client reports attendance in an outside support group: Yes ☐ No ☐

Date and Results of UA (when applicable): Date _____ Positive ☐ Negative ☐

Aftercare Recommendations (when applicable) or Additional Comments:

IMPORTANT: Please forward discharge summary with recommendations to TEAM when services have been terminated.

Submit completed forms via email or fax to TEAM

TEAM Corporation
Roseville Office Plaza, 1970 Oakcrest Avenue - Suite 200, Roseville, MN 55113
Duluth Labor Temple, 2002 London Road - Suite 95, Duluth, MN 55812
team@team-mn.com
Main: 651.642.0182 | Duluth: 218.727.8589 | Toll Free: 800.634.7710 | Fax: 651.642.1809