



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 authorization for in/outpatient CD treatment, please use the "Authorization Request for Chemical Dependency Evaluation" or " Authorization Request 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

Today's Date

Admission Date:

Expected Discharge Date

Program (inpatient, outpatient, relapse, aftercare)

Clinician's Name

Clinician's Phone #

Clinical Progress

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 fax discharge summary with recommendations to T.E.A.M. when services have been terminated.

Please fax updates to T.E.A.M. at (651) 642-1809