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 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

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