Louisiana Physical Therapy Board
2110 W. Pinhook Rd., Ste. 202 | Lafayette, Louisiana 70508
Phone 337-262-1043 | Fax 337-262-1054

Psychiatrist /Addictionist Report Form

A. Participant: ____

B. Treating Physician: ____

a. Address: ____

b. Phone:(   ) _______________ Fax: (   )___________________

C. Reporting Period: ____
(Indicate month or months client was seen)

D. Diagnosis or reason for visit :_______________________________________

E. Provide a brief comment regarding the progress made in treatment (or the lack thereof): ____
____
____
____
____

F. Current medication or change in medication: ______________________________
____
____

G. Frequency of sessions: ___________________(weekly, monthly, quarterly, etc)

Next scheduled session: ____

H. Number of sessions scheduled: ______ Number of sessions attended: ________

I. Reason(s) for missed sessions:____
____

J. Provided copy of Consent Order and/or Participation Agreement? Y N

K. Provided copy of Evaluation/Discharge Summary from primary provider? Y N

L. AA/NA attendance reported: Y N N/A

M. Any known alcohol or drug use: Y N N/A

N. Compliant with treatment: Y N

O. Anticipated date of completion of treatment: ______________________________

_________________________________ _________________________
Signature Date

PLEASE MAIL; DO NOT FAX AS FAXED COPIES WILL NOT BE ACCEPTED.