



NEW MEXICO MONITORED TREATMENT PROGRAM

MENTAL HEALTH PROVIDER REPORT: To be submitted to MTP *by participant* each month by the 10th of the month for the preceding month.

Participant Name: _____ Reporting Period _____

Provider _____ Phone _____

Attendance: () Weekly () Twice a month () Monthly
() Satisfactory
() Unsatisfactory (please explain)

Participation:
() Satisfactory
() Unsatisfactory (please explain)

Has the participant established treatment goals?
() Yes
() No (please explain)

Is participant making satisfactory progress toward achievement of treatment goals?
() Yes
() No (please explain)

Treatment Plan: Have there been any changes in the treatment plan since your last report? (i.e. frequency of therapy, change in goals, new treatment modalities, etc.)
() No
() Yes (please explain)

Is there any indication of behavioral or chemical relapse?
() No
() Yes (please explain)

Does the individual appear to be benefiting from participation in individual psychotherapy?
() Yes
() No (please explain)

Additional Comments:

Signature of Provider

Date