8507 COURT ORDERED COMMITMENT

MONTHLY PROGRESS REPORT

*This form is due, by the 5th of the month, to BHA Justice Services at mdh.bhajstxproviders@maryland.gov*

REPORTING PERIOD

Month       Year

CONSUMER INFORMATION

|  |  |  |
| --- | --- | --- |
| NAME:  |  DOB:  | AGE:  |
| RACE:  | GENDER:  | SID #:  |

COURT INFORMATION

|  |  |  |
| --- | --- | --- |
| COURT:  | JUDGE:  | NEXT HEARING DATE:  |
| CASE #:  | CASE #:  | CASE #:  |
| LEGAL STATUS: |

**SOMATIC HEALTH INFORMATION**

|  |  |
| --- | --- |
| CONDITION(S):  | MEDICATION(S):  |
| ALLERGIES:  |

**MEDICATION-ASSISTED TREATMENT INFORMATION**

|  |  |
| --- | --- |
| MEDICATION:  | PROVIDER:  |

**RESIDENTIAL PROVIDER INFORMATION**

|  |
| --- |
| PROGRAM NAME:  |
| ADDRESS:  | PHONE:  |
| ASAM LEVEL OF CARE: | ADMISSION DATE: |

**SECTION I: SUBSTANCE USE DISORDER TREATMENT**

**Counselor Name: Phone: E-mail:**

|  |  |
| --- | --- |
| **Treatment Compliance** ***Compliance during the last 30 days of treatment.*** | CounselingAttended all scheduled individual and group counseling sessions? [ ]  Yes [ ]  No Date of last sessions: Individual       Group       UrinalysisSubmitted all required urinalysis? [ ]  Yes [ ]  No Date of last urinalysis screen:      Results:        |

Provider Narrative

Indicate # of missed sessions and/or urinalysis screens, positive urinalysis results, interventions for missed sessions and/or relapses, concerns (new and ongoing) being addressed in treatment, and any progress made by consumer.

CRIMINAL JUSTICE

MONTHLY PROGRESS REPORT

CONSUMER NAME:

**SECTION II: MENTAL HEALTH TREATMENT**

**Therapist Name: Phone: E-mail:**

**Psychiatrist Name: Phone: E-mail:**

|  |  |
| --- | --- |
| **DSM V Diagnosis** |        |
| **Treatment Compliance** ***Compliance during the last 30 days of treatment.*** | TherapyAttended all scheduled therapy sessions? [ ]  Yes [ ]  No Date of last therapy session:      PsychiatryAttended all scheduled doctor appointments? [ ]  Yes [ ]  No Date of last appointment:       |

**Psychotropic Medications** *(attach additional sheet -if necessary)*

|  |  |
| --- | --- |
| **Name****Dosage****Condition Treated** |                 |
| **Name****Dosage****Condition Treated** |                 |
| **Name****Dosage****Condition Treated** |                 |
| **Name****Dosage****Condition Treated** |                 |

Provider Narrative

Indicate # of missed sessions/doctor’s appointments, interventions for missed sessions/appointments, concerns (new and ongoing) being addressed in treatment, medication concerns and/or adjustments made, and any progress made by consumer.

Counselor Signature Date

Supervisor Signature Date

Attach additional sheets – if necessary