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.*** | Counseling  Attended all scheduled individual and group counseling sessions?  Yes  No  Date of last sessions: Individual       Group  Urinalysis  Submitted 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.*** | Therapy  Attended all scheduled therapy sessions?  Yes  No  Date of last therapy session:  Psychiatry  Attended 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