

Missouri State Board of Nursing
3605 Missouri Boulevard
Jefferson City, MO 65101

Quarterly Chemical Dependency/Mental Health Continuing Treatment Form

Instructions to evaluator: This form is not to be used to fulfill the requirement for the initial chemical dependency evaluation. Please complete this form to assist the Board of Nursing in monitoring the nurse. This nurse is required to provide you with a copy of the Order. One of the conditions of this discipline is that the nurse must continue treatment for chemical dependency/mental health as long as it is recommended by the evaluator. The nurse will provide you with due dates.

Today's Date:	Date Therapy Began:	
Nurse Name:	License number:	
Number of sessions attended since last report:		
Number of sessions missed/cancelled since last report:		
Reason for Absence (brief description):		
Current Diagnosis:		
Current Treatment recommendations:		
Please rate the Participant using the scale indicated below: 5= Excellent and 1= Poor		
	RATING	COMMENTS
Participation at Sessions	5—4—3—2—1	
Problem Solving Ability	5—4—3—2—1	
Support Systems	5—4—3—2—1	
Compliance with Treatment Plan	5—4—3—2—1	
Understanding and Integration of Treatment Plan	5—4—3—2—1	
Progress in Treatment	5—4—3—2—1	
Stability in Recovery	5—4—3—2—1	
Did the nurse report a relapse?	No Yes	Was the relapse reported? If so, when?
Is continued treatment recommended?	No Yes	
Is attendance at support group required?	No Yes (if yes frequency)	
Please fill out the prescription identification form if any medications were prescribed, adjusted or discontinued		
Signature and Credentials of evaluator:		
Name and Address of Agency/Institution:		
Agency/Institution Phone number:		

Return Completed Form to:

Missouri State Board of Nursing
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