PAS
Peer Assistance Services

Peer Health Assistance Program
Therapist Report

As a treatment provider, PHAP relies upon you to provide current information regarding the licensee's ability to practice with reasonable skill and safety, based on his/her/their presentation during session or afterhours engagement with you. Please review the categories below for any concerns.

PAS Client:

Reporting Frequency: ☐ Monthly ☐ Quarterly Reporting Period:

Please indicate the level of treatment the client is participating in:
☐ Residential ☐ Intensive Outpatient ☐ Outpatient ☐ Continuing Care ☐ Individual Therapy ☐ Other _____

Frequency of contact with Licensee: ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Other _____

Has the licensee complied with scheduled sessions? ☐ Yes ☐ No
If not, please explain in detail *(scheduling concerns, what type, reschedules)*:

Is the licensee engaged in the therapeutic process? ☐ Yes ☐No
Describe progress made towards treatment goals:

Assessment of mental status:

Assessment of substance use:

Have you observed any of the following patterns of behavior that may impair the licensee's ability to practice in his/her/their licensed profession with reasonable skill and safety?

Mood shifts/swings	☐Yes ☐No	Threats of harm to self Threat of harm to others Tactile,	☐Yes ☐No ☐Yes ☐No
Tangentiality	☐Yes ☐No	visual, and/or auditory hallucinations	☐Yes ☐No
Changes in eating/ sleeping patterns	☐Yes ☐No		
Significant life event (loss, illness)	☐Yes ☐No	Impaired insight or judgement	☐Yes ☐No

If yes, please explain and **contact the PAS Case Manager IMMEDIATELY:**

The above named licensee does **not** have a behavioral health issue that renders him/her/them unable to practice in the licensed profession with reasonable skill and safety. ☐ Agree ☐ Disagree

The above named licensee does **not** exhibit compulsive patterns of behavior or those indicative of a return to use that may impair his/her/their ability to practice in the licensed profession with reasonable skill and safety.

☐ Agree ☐ Disagree

If disagree, please explain:

Thank you for your time completing this report. Your role as a treatment provider is critical to the success of this licensee. Please do not hesitate to contact the Case Manager with any questions or concerns at 303-369-0039.

Therapist Signature: Date:

Therapist Name: Therapist Credentials:

Title: Facility/Agency:

Email Address: Phone: