Wisconsin Department of Safety and Professional Services

Mail to: P.O. Box 7190
Madison, WI 53707-7190

Location: 4822 Madison Yards Way
Madison, WI 53705

FAX #: (608) 266-2264
Phone #: (608) 266-2112

Email: DSPSImpairedProfessionalProcedure@wi.gov
Website: http://dsps.wi.gov

PROFESSIONAL ASSISTANCE PROCEDURE

THERAPY REPORT

Complete this form and submit it to PAP to the address listed above on or before each quarterly due date. You may copy this blank form so you have forms for future reports. It is recommended you keep a copy of each completed form for your files.

Please Print Clearly

Client Name: _____
Last First Middle

Report Due Date: _____
Month / Day / Year

Dates of therapy contact during the last quarter:

_____ Month / Day / Year	_____ Month / Day / Year	_____ Month / Day / Year	_____ Month / Day / Year
_____ Month / Day / Year	_____ Month / Day / Year	_____ Month / Day / Year	_____ Month / Day / Year
_____ Month / Day / Year	_____ Month / Day / Year	_____ Month / Day / Year	_____ Month / Day / Year

1. What progress has this client made during the last quarter? _____
_____
_____
_____

2. Do you have any concerns regarding this client's recovery? _____ Yes _____ No
If so, explain further._____
_____
_____

3. Do you believe this client attends 12-step meetings? _____ Yes _____ No
How many/wk? _____

4. Is this client working the 12-steps? _____ Yes _____ No
If so, which step? _____

5. Does this client have and appropriately utilize a sponsor? _____ Yes _____ No

6. Describe the client's acceptance of addictive disease and his/her willingness to acknowledge and accept the consequences of the disease. _____

_____

_____

_____

7. To the best of your knowledge, is this client remaining abstinent? _____ Yes _____ No

8. Is the client having difficulty doing so? _____ Yes _____ No
Report slips/relapses immediately.

9. Does the client participate in individual sessions? _____ Yes _____ No
Does the client participate in group sessions? _____ Yes _____ No

Facilitator: _____

10. Discuss difficulties you have encountered providing services for this client to meet the requirements of the Professional Assistance Procedure. _____

_____

_____

11. Do you recommend modifications in this client's treatment plan? _____ Yes _____ No
If yes, provide clinical justification. **Modifications may not be implemented until approved by PAP.**

_____

_____

_____

12. Do you feel this client is able to safely practice his/her profession? _____ Yes _____ No
If no, explain further**.**

_____

_____

_____

13. Prognosis: _____

14. Additional comments (attach additional sheets if necessary): _____

_____

_____

_____

_____ _____

Signature and Title of Therapist Date (month / day / year)

_____

Address (city / state / zip code)

_____

Print Name of Therapist

(_____) _____

Phone Number