

MARYLAND ALCOHOL AND DRUG ABUSE ADMINISTRATION
HEALTH GENERAL 8507
MONTHLY PROGRESS REPORT

The progress report should be forwarded to ADAA by the 5th of every month. In addition, a current report must be submitted to Parole/Probation, and the Court. Submit report to the Court two (2) days prior to the date of any Court hearing. The report should summarize the defendant's progress during the previous month.

Please type or print your responses. Please place **N/A** next to any questions that do not apply to the defendant.

HEARING DATE: _____ DEFENDANT'S NAME: _____
ADMISSION DATE: _____ PROJECTED DISCHARGE DATE: _____

PROGRESS REPORT FOR PERIOD FROM _____ TO _____

PROGRAM: _____ PHONE: _____
COUNSELOR: _____ FAX: _____

LEVEL OF COMPLIANCE WITH TREATMENT PLAN:

_____ Excellent _____ Very Good _____ Good _____ Fair _____ Poor

SUBSTANCE ABUSE TREATMENT

LEVEL OF INSIGHT INTO SUBSTANCE PROBLEM

___ Denies illness ___ Minimizes illness ___ Increasing insight ___ Behavior change based on insight

Treatment strategy employed to improve insight: _____

ATTENDANCE AND PARTICIPATION

URINALYSIS

_____ Met attendance requirement for program

Submitted ___ out of ___ Samples
_____ Positive tests

Compared to last report, attendance & participation is: ___ Improving ___ Declining ___ No change

Plan to address problem:

MENTAL HEALTH TREATMENT

DIAGNOSTIC IMPRESSION: _____

MEDICATION PRESCRIBED: _____

Reason for any change in medication: _____

MEDICATION COMPLIANCE: _____ Compliant _____ Noncompliant _____ NA

Plan to address compliance problems: _____

TREATMENT SERVICES PROVIDED: _____ Individual _____ Group _____ Both _____ Other
(Describe) _____

Treatment provided by: _____ Psychiatrist _____ Psychologist _____ Clinical Social Worker
Substance Abuse Counselor _____ Psychiatric Nurse _____ Other

_____ Psychiatrist provides medication management only. Frequency: _____

Attended _____ out of _____ Individual sessions

Attended _____ out of _____ group sessions

Plan to address any attendance problems: _____

MEDICAL

SIGNIFICANT HEALTH PROBLEMS: _____

MEDICATIONS; _____

AFTERCARE PLAN

LIVING ARRANGEMENT: ___ Halfway house ___ Recovery house ___ With relative ___ Independent

Will reside with: _____

Address: _____

Will be available on: _____

EMPLOYMENT: Name of business: _____ Address: _____

Will begin on: _____

EDUCATIONAL OR VOCATIONAL TRAINING: Where: _____

Will begin on: _____

FINANCES: _____ Public Assistance (MA, AFDC, Pharmacy Assistance, Food stamps)

Primary Adult Care (PAC) yes _____ no _____ Application submitted _____

Will receive on: _____
___ SSI Will receive on: _____ ___ Social Security Will receive on: _____

SUBSTANCE ABUSE TREATMENT: Name of Program: _____

Will begin on: _____

MENTAL HEALTH TREATMENT: Name of Program: _____

Will begin on: _____

CASE MANAGEMENT services to be provided by: _____

Will begin on: _____ Case manager met with counselor and defendant on _____

Trauma Counseling: Name of program: _____

Will begin on: _____

Parenting Counseling: Name of program: _____

Will begin on: _____

Medical (Describe): _____

Appointment scheduled: _____

CONTACTS WITH DEFENDANT'S SUPERVISING/MONITORING AGENT

Name of Agent/Monitor: _____

Agency: _____

Telephone communication on: _____

Meeting on: _____

Plan reviewed on: _____

REQUEST FOR COURT INTERVENTION

___ On and off grounds privileges ___ Sanction ___ Meeting with Supervising/Monitoring Agent

(PTS, Probation, FAST, ADAA or designee) ___ Termination due to noncompliance

