LICENSED COUNSELOR REPORT

Please check which stipulation this report fulfills:

☐ Aftercare/Substance Abuse Counseling

☐ Psychiatric Report

☐ Mental Health Professional

Client Name: ____
(Please print or type)

Report Date: ____

Counselor Name: ____
(Please print or type)

Facility Name:____

---

1. Diagnosis:

2. Treatment Plan (include symptoms/problems, objectives, modality, frequency, and progress to date):

3. Current Psychosocial Status (include current living situation, work, family, and community supports):

4. Any significant stressors or adjustments within nursing practice:

Name of Client____

5. Medications:

6. Describe recovery activities for substance abuse:
   Sobriety Date:

7. What were the dates of treatment:

8. Additional Comments:

Signature of Licensed Counselor:____

Address: ____
(Please print or type)
Phone:
____

Please submit to:

Nevada State Board of Nursing
5011 Meadowood Mall Way, #300
Reno, Nevada 89502
FAX: 775-687-7729
Phone 1-775-687-7723

Revision approved by the Disability Advisory Committee on October 19, 2007