



Ohio Board of Nursing

www.nursing.ohio.gov

17 S. High Street, Suite 660 • Columbus, Ohio 43215-3466 • 614-466-3947

SUBSTANCE ABUSE TREATMENT PROGRAM REPORT

NURSE'S NAME _____ (Check One)
 INITIAL REPORT _____
 DATE _____ PROGRESS REPORT _____
 TREATMENT PROGRAM _____
 ADDRESS _____ PHONE () _____

DESCRIBE NURSE'S PROGRESS RELATIVE TO THE TREATMENT PLAN. INCLUDE CURRENT STATUS AND PROGRESS MADE IN OBJECTIVES TERMS:

FOR INTIAL REPORTS ONLY (UNLESS CHANGES OCCUR):

NURSE'S DIAGNOSIS _____

BRIEFLY DESCRIBE YOUR PROGRAM. INCLUDE PHILOSOPHY, STAFFING, IN-PATIENT FACILITIES & OUTPATIENT FOLLOW-UP:

DOES THE NURSE ATTEND AFTERCARE REGULARLY? IF NO, PLEASE EXPLAIN:

DESCRIBE TREATMENT PLAN FOR THIS NURSE _____

*ATTACH A COPY OF THE CONTRACT SIGNED BY NURSE

*WHEN NURSE IS DISCHARGED: SEND A DISCHARGE SUMMARY WITH FOLLOW-UP PLAN AND PROGNOSIS.

Signature and Title of person completing form

FORM MAY BE PHOTOCOPIED