



Washington Health Professional Services  
PO Box 47864  
Olympia, WA 98504-7864

### TREATMENT REPORT

The Washington Health Professional Services Program (WHPS) requires a monthly report of the nurse's progress as a condition of compliance with the monitoring program. Please be specific in your answers and return this form to WHPS by fax (360-664-8588) or email ([whps@doh.wa.gov](mailto:whps@doh.wa.gov))

<b>Reporting Period:</b> From: _____ To: _____		<b>Check one:</b> <input type="checkbox"/> CDP <input type="checkbox"/> MHC <input type="checkbox"/> PSYC <input type="checkbox"/> Other: _____	
<b>Client Information</b>			
Name: _____		Telephone: _____	
Address: _____			
City: _____	State: _____	Zip Code: _____	Email: _____
Have you read the contract between the client and WHPS? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you understand the terms and conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Questions or Comments:  			
<b>Treatment Plan</b>			
How long have you been working with this client? Type of treatment and program:  			
Treatment goals:  			
<b>Progress to Date</b>			
Amount of time the nurse spends in treatment:	Hrs/wk: _____	Hrs/mo: _____	
Client's progress towards treatment goals:  			
Prognosis of treatment:  			
Estimated length of continued treatment:  			
Family/Partner involvement and/or support in treatment:  			
Other Comments:  			
Signature: _____		Date: _____	
Print Name: _____		Name of Agency: _____	
Address: _____			
City: _____	State: _____	Zip Code: _____	Telephone: _____