ADMINISTRATIVE OFFICE
OF THE COURTS
Problem Solving Treatment Courts

Treatment Status Review

(Please fill out all blank fields)

*Please check one

☐ Adult Drug Court	☐ Juvenile Mental Health
☐ Adult Pre-Trial Intervention	☐ Marchman Act
☐ Family Dependency	☐ Mental Health
☐ JDP/Civil Citation	☐ Veterans (VTC)

CLIENT INFORMATION					
Date of Report:					
First Name:		MI:		Last Name:	

PROVIDER/AGENCY INFORMATION		
Provider Name:	Counselor Name:	Counselor Email Address:

TREATMENT											
Date of Intake at Current LOC (level of care):		Estimated Completion Date at Current LOC:									
Level of Care:	Residential ☐	Intensive Outpatient ☐	Out-patient ☐	Aftercare ☐	Recovery Support ☐	Other ☐					
Medication: *Compliant*	☐ Yes	☐ No	☐ N/A	Were medications verified by supporting documents?	☐ Yes	☐ No					
List of Medications:											
MAT Dosage:	Methadone ☐		Buprenorphine ☐		Vivitrol ☐		Other ☐				
MAT Provider Name:		Was MAT Provider verified by supporting documents?	☐ Yes	☐ No							

PROGRAM ATTENDANCE: *Since Last Report* *For Residential, please only add # of total hours per week for group sessions*			
Service Activity	Attended (Date, Time & # of Hours)	Excused (Reason, documents supplied)	Unexcused
Individual Sessions			
Group Sessions			
Specify the Treatment Schedule: (M-W-F 9:00am – 11:00am)			
The Client is COMPLIANT with their treatment plan.	☐		
The Client is NOT COMPLIANT with their treatment plan.	☐		
The Client is COMPLIANT with some concerns	☐		
Therapeutic Response (if applicable):			

First Name:		MI:		Last Name:	

*Therapist/Case Manager Comments (Please report positive changes, accomplishments, and/or challenges to treatment):

Current Prognosis:	☐ Good ☐ Fair ☐ Poor
Level of Care:	Increase ☐ Decrease ☐ Stay the Same ☐

*Recommendations/Discharge Plan/Transition Plan:

The exchange of information is only limited to compliance with the conditions of the Treatment Plan and not to any other confidential information.

URINE DRUG SCREENS (UDS): *Since Last Court Date**

UDS Date:	Panel #:	RESULTS: Please check either Pending, Negative or Positive *(If Positive Indicate Drug)*					
		☐ Pending	☐ Negative	☐ Positive	Drug Name:		☐ No Show
		☐ Pending	☐ Negative	☐ Positive	Drug Name:		☐ No Show
		☐ Pending	☐ Negative	☐ Positive	Drug Name:		☐ No Show
		☐ Pending	☐ Negative	☐ Positive	Drug Name:		☐ No Show
		☐ Pending	☐ Negative	☐ Positive	Drug Name:		☐ No Show
		☐ Pending	☐ Negative	☐ Positive	Drug Name:		☐ No Show
		☐ Pending	☐ Negative	☐ Positive	Drug Name:		☐ No Show
		☐ Pending	☐ Negative	☐ Positive	Drug Name:		☐ No Show
		☐ Pending	☐ Negative	☐ Positive	Drug Name:		☐ No Show
		☐ Pending	☐ Negative	☐ Positive	Drug Name:		☐ No Show
Notes:							

Support Group/Meetings Attendance (AA/NA/PTSD):	☐ Yes	☐ No	☐ N/A	# Per Week	
Are meetings verified?	☐ Yes	☐ No	☐ N/A		
Compliant with Visitation Court Order:					
If No, please explain:					

______________________________ ______________________

Agency Representative Date

This report serves exclusively to verify the progress and overall treatment status of referred individuals and participants of the Hillsborough County, Problem-Solving Treatment Courts. I hereby certify that the information provided above is true, correct and complete to the best of my knowledge.