UPHP

Therapist Report

Participant's Name: _____ Therapist's Name: _____

Participant's Professional Duties: _____ Dates Seen: _____

Were there any missed appointments? ❑ No ❑ Yes Dates? _____

Diagnosis (DSM-5) _____

_____

Current Medications: _____

_____

Issues Addressed in Therapy: _____

_____

Treatment Goals: _____

_____

Evaluation of Progress: _____

_____

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Do you want UPHP to contact you? ❑ No ❑ Yes

Do you have any concerns about the participant ability to practice safely? ❑ No ❑ Yes

Signature: _____ Date: _____

Please email to UPHP@Utah.gov. If you have questions or concerns, please contact UPHP at 801-530-6428