Name: _____ Date: _____

Drug Abuse Treatment

Fill this worksheet.

	Other Agencies Involved	Plan to Coordinate Services

Problem Statement (In Client's Words)

_____

_____

_____

Diagnoses:

_____

_____

_____

Justification for Diagnosis Change (If applicable):

_____

_____

_____

Medication Information:

Medication(s):	Dose:	Frequency:	Indication: