



DOH 630-101 November 2020

Therapist 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 fax the completed form to WHPS via fax (360-359-7956) or email (whps@doh.wa.gov).

Reporting Month/Year:	Type of Services (check all that apply):	Mental Health Therapy: <input type="checkbox"/> SUD Treatment: <input type="checkbox"/> Pain Management: <input type="checkbox"/> Other (please explain): <input type="checkbox"/> _____
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Nurse Information

Name:
Are you aware of the nurse's participation in the WHPS Program? Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you discussed and understand the terms and conditions of the program? Yes <input type="checkbox"/> No <input type="checkbox"/>
Questions or Comments:

Service Plan

How long have you been working with this nurse? Years: _____ Months: _____
Goal(s):

Monthly Progress

Are session(s) monthly or weekly?	Number of hours per session:
Nurse's progress towards goals:	
Prognosis:	
Estimated completion date:	
Family/partner involvement and/or support:	
Additional comments:	

Signature:	Print Name:	Date:
Address:		Name of Agency:
City:	State:	Zip Code: Telephone:

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