Form 13

Ohio Board of Nursing

www.state.oh.us/nur

17 South High Street, Suite 400 • Columbus, Ohio 43215-3413 • (614) 466-3947

SUBSTANCE ABUSE TREATMENT PROGRAM REPORT

NURSE'S NAME _____ (Check One) INITIAL REPORT _____

DATE_____ PROGRESS REPORT _____

TREATMENT PROGRAM _____

ADDRESS _____ PHONE ( ) _____

_____

DESCRIBE NURSE'S PROGRESS RELATIVE TO THE TREATMENT PLAN. INCLUDE CURRENT STATUS AND PROGRESS MADE IN OBJECTIVES TERMS:

_____

_____

_____

FOR INTIAL REPORTS ONLY (UNLESS CHANGES OCCUR):

NURSE'S DIAGNOSIS _____

BRIEFLY DESCRIBE YOUR PROGRAM. INCLUDE PHILOSPHY, STAFFING, IN-PATIENT FACILITIES & OUTPATIENT FOLLOW-UP:

_____

_____

DOES THE NURSE ATTEND AFTERCARE REGULARLY? IF NO, PLEASE EXPLAIN:

_____

_____

DESCRIBE TREATMENT PLAN FOR THIS NURSE _____

_____

_____

*ATTACH A COPY OF THE CONTRACT SIGNED BY NURSE
*WHEN NURSE IS DISCHARGED: SEND A DISCHARGE SUMMARY WITH FOLLOW-UP PLAN AND PROGNOSIS.

_____

_____
Signature and Title of person completing form

FORM MAY BE PHOTOCOPIED

NUR 1504