

**ARIZONA STATE BOARD OF NURSING**  
**4747 NORTH 7TH STREET, SUITE 200**  
**PHOENIX, ARIZONA 85014-3655**  
**TELEPHONE (602) 771-7800      FAX (602) 771-7882**

**ATTENTION: "MONITORING"**

**INDIVIDUAL COUNSELING REPORT**

\_\_\_\_\_ is required to have submitted on his/her behalf, a counselor report and evaluation every \_\_\_\_\_ months. Please complete this form and return it to the address shown above.

Report On: \_\_\_\_\_  
Name of Nurse Receiving Individual Counseling

Type of Counseling (check all that applies):

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Aftercare     | <input type="checkbox"/> Relapse Prevention Therapy |
| <input type="checkbox"/> Psychiatric    | <input type="checkbox"/> Psychological | <input type="checkbox"/> Medical                    |
| <input type="checkbox"/> Other _____    |  |   |

Date of Report: \_\_\_\_\_ Date Counseling Began: \_\_\_\_\_

Number of Sessions (since the last report) That Were: **Attended** \_\_\_\_\_ **Missed** \_\_\_\_\_

If Missed, Reasons Given for Absence: \_\_\_\_\_

Problem Areas Addressed in Counseling: \_\_\_\_\_

Is this Nurse Making Satisfactory Progress:  Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_

Referrals or Recommendations Made to Nurse: \_\_\_\_\_

Compliance with Previous Referrals or Recommendations: \_\_\_\_\_

\_\_\_\_\_  
Name and Title of Counselor

\_\_\_\_\_  
Agency

\_\_\_\_\_  
Signature of Counselor

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone #

\_\_\_\_\_  
City/State

\_\_\_\_\_  
Zip