RAMP
RECOVERY & MONITORING PROGRAM
INSTITUTE FOR NURSING

609-883-5335 | Fax 609-883-1544
Peer Assistance Hotline: 800-662-0108
www.NJSNA.org

Judy Schmidt, RN, MSN, ONC, CCRN
Chief Executive Officer

Jillian Scott, RN, MSN
RAMP Director

Therapy Evaluation
(To be completed by aftercare counselor or therapist)

Participant: _____ **Participant #** _____

Report: Month _____ **Year** _____

Please rate the following:
Attends sessions regularly.

Unsatisfactory			**Satisfactory**
1	2	3	4

Actively participates in sessions.

Unsatisfactory			**Satisfactory**
1	2	3	4

Shares experiences and feelings freely.

Unsatisfactory			**Satisfactory**
1	2	3	4

Appears actively involved in own recovery process.

Unsatisfactory			**Satisfactory**
1	2	3	4

Dates of Sessions Attended: _____

Dates & Results of Urine Drug Screens: _____

COMMENTS:_____
_____
_____

UPON DISCHARGE, PLEASE ANSWER THE FOLLOWING QUESTION:
Is the participant able to practice their profession safely and competently as it relates to their Addictive Disease or Mental Illness? YES____ NO____

_____ _____
Therapists Name (printed) **Phone #**

_____ _____
Therapists Signature **Date**