

Judy Schmidt, MSN, DHA(c) RN, CCRN  
 Chief Executive Officer

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 RAMP Director

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

**Participant:** \_\_\_\_\_ **Participant #** \_\_\_\_\_

**Report: Month** \_\_\_\_\_ **Year** \_\_\_\_\_

**Please rate the following:**

Attends sessions regularly.

<b>Unsatisfactory</b>				<b>Satisfactory</b>
1	2	3	4	

Actively participates in sessions.

<b>Unsatisfactory</b>				<b>Satisfactory</b>
1	2	3	4	

Shares experiences and feelings freely.

<b>Unsatisfactory</b>				<b>Satisfactory</b>
1	2	3	4	

Appears actively involved in own recovery process.

<b>Unsatisfactory</b>				<b>Satisfactory</b>
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**