Nevada State Board of

# NURSING

## Licensed Counselor Report

Client Name: ______________________________ Report Date: ____________________

*(Please print or type)*

Counselor Name: ______________________________________________

Facility Name: ______________________________________________

Please check the stipulation(s) this report fulfills:

- ☐ Aftercare/Substance Use Disorder Counseling
- ☐ Psychiatric Report
- ☐ Mental Health Professional

Attach additional pages as needed

1. Diagnosis:
2. Treatment Plan (*include symptoms/problems, objectives, modality, frequency, and progress to date):*
3. Current Psychosocial Status (*include current living situation, work, family, and community supports):*
4. Significant stressors or adjustments within nursing practice:
5. Medications:
6. Describe recovery activities for substance use disorder:
   Sobriety Date:
7. Dates of treatment:
8. Additional comments:

Counselor Signature: ______________________________________________

Address: ______________________________________________

Telephone: ____________________ E-mail: ____________________

**Fax completed forms to: 775-687-7729** (Please do not fax multiple copies)
Or mail to: NSBN, Compliance Coordinator, 5011 Meadowood Mall Way, Ste 300, Reno, NV 89502-6576