

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: _____

E-mail completed forms to: compliance@nevadanursingboard.org or;

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