Nevada State Board of
NURSING

Licensed Counselor Report

Client Name ____ Sobriety Date: ______________________

Counselor Name: ____ Report Date: ______________________

Please check the stipulation(s) this report fulfills:

☐ Aftercare/Substance Use Disorder Counseling ☐ Psychiatric/Mental Health Provider Report

Attach additional pages as needed

1. Diagnosis:

2. Treatment Plan (*include symptoms/problems, objectives/goals, 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. Current list of medications:

6. Describe recovery activities for substance use disorder:

7. Dates of treatment:

8. Additional comments:

Counselor Signature: ____

Address: ____

Telephone: __________________________________ E-mail: ____

Please submit through your SPECTRUM account