REVIEW OF TREATMENT PLAN

State Form 46497 (3-94)

Department of Correction
Substance Abuse Program

Facility
Date (month, day, year)

Name of client / offender	DOC number	Plan review number

Offender sees own progress on goals and objectives as:

☐ Good ☐ Satisfactory ☐ Fair ☐ Poor

Peers see offender's progression on goals and objectives (if applicable)

☐ Good ☐ Satisfactory ☐ Fair ☐ Poor

Offender ☐ is / ☐ is not attending and participating in program meetings.

Offender ☐ is / ☐ is not attending self help group meetings.

Offender ☐ is / ☐ is not completing required assignments.

ASSESSMENT

Staff assessment on offender's treatment plan, goals and objectives are:

☐ Good ☐ Satisfactory ☐ Fair ☐ Poor

Offender is seen by staff as:

Current treatment plan is appropriate ☐ Yes ☐ No		If No, treatment plan will be updated on: (month, day, year)	
Signature of staff	Date signed (mo., day, year)	Signature of staff	Date signed (mo., day, year)
Signature of staff	Date signed (mo., day, year)	Signature of staff	Date signed (mo., day, year)
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