Reset Form

ALTERNATIVE CLINICAL PROVIDER
CLIENT CONTACT LOG
INDIANA ACCESS TO RECOVERY (ATR)

State Form 55010 (6-12)

Name of client			
Start date *(month, day, year)*	Start time	End date *(month, day, year)*	End time
ATR units		Encounter identification number	

CLINICAL SERVICES – *Select only one box for each log entry.*

** For all services with an asterisk (*) there must be an invoice/receipt in the client file for each log entry.*

☐ Assessment - Diagnostic Interview	☐ Detoxification	☐ Individual Addictions Treatment
☐ Int. Treatment of Co-occur. Disease*	☐ IOP - Min. 2 hour sessions - Group	☐ Outpatient - Min. 2 hour sessions - Group
☐ Cont. Care Counseling - Group	☐ MAT- Methadone	☐ MAT - Naltrexone
☐ MAT- Disulfiram	☐ MAT- Acamprosate Calcium	☐ MAT - Buprenorphine

NOTES

What occurred during the session, what was the topic, and what did I learn?

How will I use the information for my recovery?

CLIENT PROGRESS – *To be completed by Rendering Staff.*

Check one:

☐ Client did participate. ☐ Client did not participate.

Notes

What is next for the client, or when should the client expect to return to for further assistance with their recovery?

By signing this contact log I certify under penalty of perjury that the above information is correct and accurate.

Signature of client	Date *(month, day, year)*
Signature of rendering staff	Date *(month, day, year)*