The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
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Pharmacy Substance Use Disorder (PSUD) Program

PROFESSIONAL SUPPORT GROUP REPORT

Please complete this report on a quarterly basis, as stipulated in the PSUD Participant's Treatment Contract, and return it directly to the PSUD participant.

Name of PSUD Participant: _____

Evaluation following time period from _____ to _____

Frequency of therapy: ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Other: _____

Dates of sessions attended since last Report:

Dates of sessions missed since last report:

date(s)	*reason for absence*

Level of participation and progress in group:

Participation:	☐ Satisfactory	☐ Minimal	☐ Unsatisfactory
Progress:	☐ Satisfactory	☐ Minimal	☐ Unsatisfactory

Comments:

To the best of your knowledge, do you believe the PSUD participant named in this report is maintaining abstinence from alcohol, drugs and/or chemicals of abuse?

☐ Yes ☐ No ☐ Unsure Comments:

Recommendations:

Other comments:

_____ _____
Name of Therapist/Counselor (please print) Agency (if applicable)

☐ LCSW ☐ LICSW
☐ LMHC ☐ Psy. D
☐ LDAC-II ☐ LDAC-I
☐ CADAC-I ☐ CADAC-II
☐ LMFT ☐ Other: _____

_____
License #

Duration of counseling relationship with PSUD participant: _____