



PSYCHOTHERAPIST REPORT
Initial Consultation

TO: ___ David Bolshoun, MD ___ Edith Lovegren, MD, Ph.D. ___ Larry Plunket, MD ___ Molly Pickett, AGPCNP-BC
Fax: 303-333-6505

Date: _____ Client Name: _____ DOB: _____

Thank you for your recent referral. I met with above named client on

Presenting Concerns:

Initial Clinical Impressions/Diagnosis:

Initial Plan:

Additional Comments: (optional)

Referrals made: (optional)

(print name)

(signature):

(phone)



PSYCHOTHERAPIST REPORT
Interim Update/Follow-up

TO: ___ David Bolshoun, MD ___ Edith Lovegren, MD, Ph.D. ___ Larry Plunket, MD ___ Molly Pickett, AGPCNP-BC
Fax: 303-333-6505

Date: _____ **Client Name:** _____ **DOB:** _____

SITUATION: (What is going on with the client? A concise statement of the problem.)

BACKGROUND: (Pertinent information related only to the problem.)

ASSESSMENT: (What is happening at the present time?)

RECOMMENDATION: (What would you like to see done?)

(print name)

(signature):

(phone)



PSYCHOTHERAPIST REPORT
Termination

TO: David Bolshoun, MD Edith Lovegren, MD, Ph.D. Larry Plunket, MD Molly Pickett, AGPCNP-BC
Fax: 303-333-6505

Date:

Client Name:

DOB:

TERMINATION SUMMARY: (brief description of progress in therapy)

Termination with Goals Met

Termination without Goals Met

FINAL IMPRESSIONS/DIAGNOSIS:

RECOMMENDATION:

Referral(s) Made To:

(print name)

(signature with credentials)

(phone)