

### Colorado's Center For Mental Health

1355 S. Colorado Blvd., Suite C-100, Denver, CO 80222-3305 Phone: 303-756-9052 

Fax: 303-756-0308 

MariaDrosteoorg

# PSYCHOTHERAPIST REPORT Initial Consultation

David Bolshoun, MD	Edith Lovegren, MD, Ph.DLarry Plunket, N Fax: 303-333-6505	MDMolly Pickett, AGPCNP-BC
e: Client N	ame:	DOB:
nk you for your recent referra	. I met with above named client on	
Presenting Concerns:		
Initial Clinical Impression	s/Diagnosis:	
Initial Plan:		
Additional Comments: (or	otional)	
Referrals made: (optional)		
(print name)	(signature):	
(phone)		



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# **PSYCHOTHERAPIST REPORT**

Interim Update/Follow-up

Davi		DLarry Plunket, MDMolly Pickett, AGPCNP-BC -333-6505
:	Client Name:	DOB:
<u>SITU/</u>	ATION: (What is going on with the client? A co	ncise statement of the problem.)
BACK	GROUND: (Pertinent information related only t	o the problem.)
ASSE	SSMENT: (What is happening at the present tin	ne?)
RECO	OMMENDATION: (What would you like to see o	done?)
(print na	ame)	(signature):
(phone)		



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# **PSYCHOTHERAPIST REPORT**

# **Termination**

TO:	David Bolshoun, MDEdith Lovegren, MD, Ph.D. Fax: 303-333	Larry Plunket, MDMolly Pickett, AGPCNP-BC
Date:	Client Name:	DOB:
	TERMINATION SUMMARY: (brief description of progress	s in therapy)
	Termination with Goals Met	
	Termination without Goals Met	
	FINAL IMPRESSIONS/DIAGNOSIS:	
	RECOMMENDATION:	
	Referral(s) Made To:	
(print name)		(signature with credentials)
(phone)		