Case # _______Participants Name:_______________________________

IPN PROGRESS EVALUATION

IPN USE ONLY
-PE2

Evaluator Name (print)_______________________________ ( ) **Individual/Other Therapist**
Mailing Address: ____
City:_________________________________ ***State:*** _________ ***Zip:***________ ***County:***_____________
Evaluator email address:____@____________.___________
Telephone (_____)______________________ **Extension**__________

(PLEASE PLACE "X" BY THE APPROPRIATE NUMBER AND PROVIDE COMMENTS)

	EXCELLENT	GOOD	AVG.	BELOW AVG.	POOR
1. **Is the participant's affect/behavior appropriate?**	**5( )**	**4( )**	**3( )**	**2( )**	**1( )**
2. **Attendance at therapy sessions**	**5( )**	**4( )**	**3( )**	**2( )**	**1( )**
3. **Participation in therapy**	**5( )**	**4( )**	**3( )**	**2( )**	**1( )**
4. **Progress in recovery**	**5( )**	**4( )**	**3( )**	**2( )**	**1( )**
5. **Problem-solving ability**	**5( )**	**4( )**	**3( )**	**2( )**	**1( )**
6. **Cognitive functioning**	**5( )**	**4( )**	**3( )**	**2( )**	**1( )**
7. **Ability to cope with stressful situations**	**5( )**	**4( )**	**3( )**	**2( )**	**1( )**
8. **Judgment**	**5( )**	**4( )**	**3( )**	**2( )**	**1( )**

1. Comments: ____
____
2. Comments: ____
Unexcused Absences: ____
3. Comments: ____
____
4. Comments: ____
____
5. Comments: ____
____
6. Comments: ____
____
7. Comments: ____
____
8. Comments: ____
____

9. **Medications:** Please list all medications (including over-the-counter) that the nurse is currently taking.
____
____

10. **Demonstrating relapse behaviors** **Yes ( )** **No ( )**
If yes, list behaviors of concern: ____
____

11. **Have you observed anything in therapy sessions that could be of concern regarding this nurse's safety to practice?** **Yes ( )** **No ( )** **if yes, please explain on back.**

Signature ___________________________________ **Date** ________________________

Reviewed with participant? No ( ) / Yes ( ) If yes, participant signature ______________________

Please call the IPN Office at (800) 840-2720 to discuss any concerns or receive clarification regarding this nurse's individual monitoring plan. Thank you. **Please return this form by fax 904-270-1633 or mail to:**

IPN, P.O. Box 49130, Jacksonville Beach, FL 32240-9130

Case # _______ Participants Name: ________________________________

DATE ______________________________

COMMENTS ____