



# MONITORING REPORT

Due \_\_\_\_\_ Day of Each Month

Client Name \_\_\_\_\_

## BREATHALYZER

Dates of Breathalyzer Collection	Negative	Pending	Confirmed Positive	Initials of Observer
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

- Contact us **immediately** if a client's initial screen test is positive
- Contact us immediately if a client misses a call in. If any tests missed, please indicate reason, (e.g., vacation).

\_\_\_\_\_

Signature \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_

Name/Credentials (Please Print) \_\_\_\_\_

Facility/Agency \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

## MONITORED MEDICATION REGIME REPORT

The medication the client is being observed for is: \_\_\_\_\_

The medication dosage and frequency is: \_\_\_\_\_

Dates Medication Administered	Initials of Observer	Dates Medication Administered	Initials of Observer

Contact Peer Assistance Services immediately if licensee misses monitored medicine.

Signature \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_

Name/Credentials (Please Print) \_\_\_\_\_

Facility/Agency \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Mail Original To: Peer Assistance Services, Inc.  
 2170 S. Parker Road, Suite 229  
 Denver, CO 80231  
 Phone: 303.369.0039 or 866.369.0039  
 Fax: 720.213.1007