



MONITORING REPORT

Due _____ Day of Each Month

Client Name _____

URINE

Dates of Urine Collection	Negative	Pending	Unconfirmed Positive	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"/>	<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, regardless of whether or not the client has a prescription. **GCMS confirmation must be performed on all positive screens.**
- Attach the **GCMS** confirmation results to this form.
- If any urine collections have been missed, please indicate reason, (e.g., vacation).

The urine screens were done on a random basis as determined by _____ and were monitored by _____.

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.
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Denver, CO 80231
Phone: 303.369.0039 or 866.369.0039
Fax: 720.213.1007