Montana Stimulant Use Disorder Treatment (TRUST/CM) Project

Please complete this form the first day of every month and email to

Barbara Schott :: bschott@mtpca.org

Program Name:		**Today's Date:**	
Total Number enrolled in TRUST			
Total Number enrolled in CM			
# completed 12 wks. of TRUST/CM:	TRUST: CM:		
Number currently active:			
Number dropped out:			

UPDATE AS NEEDED

CURRENT PROGRAM INFORMATION:

Primary Contact:	
Email:	
Staff responsible for submitting form:	
Email:	

What components are you offering:	TRUST	☐
	Contingency Management	☐

Coaching Call Liaison:

Name:	
E-Mail:	

CM Staff- Who is delivering and tracking

Name:	
E-Mail:	

TRUST Therapist:

Name:	
E-Mail:	

EXERCISE Staff:

Name:	
E-Mail:	

Date First CM/TRUST Patient enrolled:	

SUBMIT