



2159 Grand Avenue
West Des Moines, 50265
Ph. 515.327.7036 Fax 515.875.4895

AA/NA SUPPORT MEETING VERIFICATION SLIP

Meeting Date: _____ Time: _____

Location: _____

What I got from this meeting/How it relates to my situation: _____

Signed: _____

Phone Number: _____



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Verification of Completion of Court Ordered Evaluation

_____ was seen for a substance abuse evaluation with Krista M. Mattson on this date _____ 20_____.

Recommendations are as follows:

Level 0.5	_____	Level 3.1	_____	Level 4	_____
Level 1.0	_____	Level 3.3	_____	Other:	_____
Level 2.1	_____	Level 3.5	_____	Notes:	_____
Level 2.5	_____	Level 3.7	_____		_____

Payment Received: _____

Balance Due: _____

Krista M. Mattson LBSW, CADDC
Assessment Services, Inc.



_____, 2007

Regarding: Courtesy Copy of Substance Abuse Evaluation

_____ County Clerk of Criminal Court,

Please find enclosed a courtesy copy of the substance abuse evaluation for the following offender:

Case Number:

Please file accordingly prior to the offenders next court date which is scheduled for _____ in room _____.

Respectfully Submitted,

Krista M. Mattson LBSW, CADAC
Assessment Services, Inc.

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