Medical Professionals Health Program

Treatment Provider Report Form—Prescriber

Provider Type (circle one): **Primary Care, Psychiatrist, Addictionist, Other**: _____

Report Date: _____ **Monthly / Quarterly / Annual Report** (circle one)

MPHP Participant Name: _____

Date(s) of appointment(s): _____

Please check the answer to each of the following questions:	**Yes**	**No**
1. Is your patient practicing healthy behaviors?	_____	_____
2. Is your patient in compliance with treatment recommendations?	_____	_____
3. Does your patient appear actively involved in his/her treatment program?	_____	_____
4. Does your patient demonstrate clear thought processes and functions?	_____	_____

Please explain any "**No**" responses: _____

_____

_____

8. Is your client required to maintain abstinence (per MPHP monitoring agreement)?	_____	_____
9. If so, do you have any concerns that your client has not maintained abstinence?	_____	_____

Please explain any concerns: _____

_____

Any change in status, diagnosis, treatment goals, or treatment modalities since the last report?

☐ **No** ☐ **Yes** (please explain) _____

_____

Review of this participant's PMP Report indicates: ☐ **Appropriate Medication Use**

☐ **Inappropriate Medication Use** (please explain)

_____

_____

_____

_____

_____

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Medications currently prescribed and/or monitored (please include dosage, amounts, and refills):

_____

_____

_____

_____

_____

Is your client compliant with his or her prescribed medication regime?

☐ **No** ☐ **Yes** (please explain) _____

_____

Do you have any concerns about medications the participant is now taking?

☐ **No** ☐ **Yes** (please explain) _____

_____

Based on what you know, do you have any concerns about this participant's ability to practice safely?

☐ **No** ☐ **Yes** (please explain) _____

_____

Additional Comments? _____

_____

_____

Do you have a current, signed release on file to share information with MPHP? ☐ **No** ☐ **Yes**

Would you like the MPHP to contact you? ☐ **No** ☐ **Yes**

_____ _____

Health Care Provider's Signature **Date**

_____ (_____) _____

Health Care Providers Name and Credentials (Printed) **Phone**

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