

Virginia Health Practitioners' Monitoring Program Monthly Treatment Report

Name of Participant: _____ Client # _____ CM: _____

Date of Report: _____ For Month: _____, 20____

Name of Treatment Program (if applicable): _____

Diagnosis:

For the above named individual, please provide your current, full Axis I-V diagnoses:

	New	Ongoing	Resolved
Axis I: _____	<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"/>
Axis II: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Axis III: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Axis IV: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Axis V: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Type of Treatment:

- Inpatient Residential Intensive Outpatient Outpatient
 Aftercare Individual Other: please specify: _____

Number of appointments scheduled: _____ Number attended: _____

Dates attended: _____ Dates Missed: _____

If missed, why and what are your concerns: _____

Current Treatment Goals (list all): _____

Participant Progress with Treatment Goals (provide details for each):

Please tell us your assessment of how this individual is doing in treatment since last month (or the last report you filed) and provide comments which support your assessment: First Report

Much Worse Somewhat Worse Same Somewhat Improved Much Improved

Is the participant compliant with treatment? Yes No

As far as you are aware, is the participant practicing his/her health profession? Yes No

Do you have any concerns about the participant's ability to practice his/her health profession? Yes No

Comments: _____

Do you need more information about the Virginia Health Practitioners' Monitoring Program (HPMP) or participant? Yes No

Do you need to speak with the participant's case manager? Yes No

Person Completing Report (Print Name): _____ Date: _____

Signature: _____ Telephone: _____

(Please fax this form to 804-828-5386 by the 10th of the month. Thank you for your cooperation!)

For Office Use Only

Date Received by HPMP: _____ Case Manager: _____