Virginia Health Practitioners' Monitoring Program
Monthly Participant Report

Name of Participant: _____ **Client #** _____ **CM:** _____

Date of Report: _____ **Reporting Month:** _____**, 20**_____

Address/Telephone: _____
Is the address/telephone a change from the last report? ☐ Yes ☐ No

Date of check-in with Case Manager for reporting month: _____

Current Medical/Mental Conditions for which I am receiving treatment:

Conditions *(☒if new)*	**Medications, if applicable** *(☒if new)*
1. ☐	☐
2. ☐	☐
3. ☐	☐
4. ☐	☐
5. ☐	☐

PCP/Medical Specialist Visits:

Primary care provider's name: _____
Date(s) of appointments: _____ ☐ N/A

Other provider's name: _____
Date(s) of appointments: _____ ☐ N/A
Specialty: _____

Treatment Attendance:

IOP or Day Treatment facilitator's name:_____ ☐ N/A
Number of appointments scheduled: _____ Dates attended: _____
Reason for missed session(s): _____

Group therapist's name:_____ ☐ N/A
Number of appointments scheduled: _____ Dates attended: _____
Reason for missed session(s): _____

Individual treatment therapist's name:_____ ☐ N/A
Number of appointments scheduled: _____ Dates attended: _____
Reason for missed session(s): _____

Psychiatrist's/Addiction Physician's name:_____ ☐ N/A
Number of appointments scheduled: _____ Dates attended: _____
Reason for missed session(s): _____

Status of Legal Issues (if applicable)**:**_____

Current Employer (include address/telephone number)**:** _____
Work site monitor's name (if applicable)**:** _____
Employer representative's name (if applicable): _____

Comments/Concerns: _____
_____
_____

(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: _____