Virginia Health Practitioners' Monitoring Program
PRN PCP/Medical Specialist Report

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

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

For the above named individual, please list the current conditions you are treating and medications you are prescribing:

		Check if new medication
Condition: _____	**Medication(s)/Dose:** _____	☐
	_____	☐
	_____	☐
Condition: _____	**Medication(s)/Dose:** _____	☐
	_____	☐
	_____	☐
Condition: _____	**Medication(s)/Dose:** _____	☐
	_____	☐
	_____	☐
Condition: _____	**Medication(s)/Dose:** _____	☐
	_____	☐
	_____	☐

Medication level /Lab results:

Date:	Test:	Result:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician visits: Number of appointments scheduled for month: _____ Dates attended: _____

Please provide your assessment of the participant's overall clinical condition: ☐ First Report
☐ Much Improved ☐ Somewhat Improved ☐ Same ☐ Somewhat Worse ☐ Much Worse

Comments/Concerns: _____

_____

To your knowledge, is the participant practicing in a health profession? ☐ Yes ☐ No

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

Do you need information about the Virginia Health Practitioners' Monitoring Program? ☐ Yes ☐ No

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

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

Name of Practice: _____

Signature: _____ Telephone: _____

(Please fax this form to 804-828-5386 within 7 days of the appointment. Thank you for your cooperation!)

For Office Use Only
Date Received by HPMP: _____ Case Manager: _____