Virginia Health Practitioners' Monitoring Program
Quarterly Psychiatrist/Addiction Medicine Physician Report

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

Date of Report: _____ **Reporting Quarter:** December-February ☐
March-May ☐
June-August ☐
September-November ☐

Please provide DSM-V diagnoses:

	Mild	Moderate	Severe
Substance Use Disorder: _____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

Mental Health: _____
_____
_____
_____

Medical Health: _____
_____

Please list medications you are currently prescribing:

Medication:	Dose:
_____	_____
_____	_____
_____	_____
_____	_____

Medication level /Lab results:

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

Is the participant compliant with treatment/medications? ☐ Yes ☐ No

Appointments: Number of appointments scheduled: _____ Dates attended: _____

How is this individual doing in treatment since last quarter (or the last report you filed): ☐ First Report
☐ Much Improved ☐ Somewhat Improved ☐ Same ☐ Somewhat Worse ☐ Much Worse

Comments: _____
_____
_____

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 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 March, June, September and December. Thank you for your cooperation!)

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