Virginia Health Practitioners' Monitoring Program
Quarterly Treatment Report

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

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

Name of Treatment Program (if applicable): _____

Please provide DSM-V diagnoses:

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

Mental Health: _____
_____
_____
_____

Medical Health: _____
_____

Type of Treatment:	**Number of appointments scheduled**	**Dates Attended**
☐ Day Treatment	_____	_____
☐ Intensive Outpatient	_____	_____
☐ Group	_____	_____
☐ Individual	_____	_____

Dates Missed: _____
If missed, why and what are your concerns: _____

Is the participant compliant with treatment? ☐ Yes ☐ No

Current treatment goals: _____
_____
_____
_____

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

Participant progress with treatment goals (provide details for each) and other 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: _____