Virginia Department of Health Professions
Board of Nursing

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# *Treatment Provider Report*

*This report covers only the current quarter of* ***20_____:*** ☐ ***Jan-Mar*** *or* ☐ ***Apr-Jun*** *or* ☐ ***Jul-Sep*** *or* ☐ ***Oct-Dec***

To be timely, this report must be received from 5 days before until 5 days after the end date of the current quarter:
*For example: if report is due 3/31, it must be received between 3/26 and 4/5.*

FAXES & EMAIL ARE ACCEPTABLE – YOUR ORIGINAL SIGNATURE IS REQUIRED & MUST BE SUBMITTED AS WELL

*The person requesting that you complete this form is under a Virginia Board Order. The Order is a public document that may be obtained online from the Board's webpage or on Nursys.com. This monitored person is Ordered to ensure timely submission of quarterly reports to the Board by their treating practitioners until they are released in writing from the Order.*

| | | |
|---|---|---|
| **Monitored Person's Name** | **Provider's Name** | |
| **Monitored Person's License/Registration/Certification #** | **Practice Name** | |
| **Practice Address** | **Provider's License #** | **Phone** |

**Do you have a complete copy of the monitored person's Board Order(s)?**

☐ *Yes, from monitored person* ☐ *Yes, from Board/website* ☐ *Yes, from Compliance Case Manager* ☐ *No*

*Diagnoses: For the above-named monitored person, please list all diagnoses known to you:*

| ***Axis/Code/Diagnosis*** | ***New*** | ***On-going*** | ***Resolved*** |
|---|---|---|---|
| | | | |
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| | | | |

*Any diagnoses NOT addressed in your treatment & recommendations:*

| | | |
|---|---|---|
| Number of visits scheduled for this past quarter: | Number of appointments NOT kept: | |

**Treatment provided & recommendations made since your last report:**

*Description:*

**Describe your assessment of the monitored person's progress in treatment since your last report:** ☐ *First Report*

☐ *Hospitalized / inpatient* ☐ *Much worse* ☐ *Somewhat worse* ☐ *Same* ☐ *Somewhat Improved* ☐ *Much Improved*

*Description:*

**Is client compliant with your treatment and recommendations?** ☐ ***Yes*** ☐ ***No***

*Description:*

*Please complete all pages of this form.*

VA BON Treatment Provider's Report: Monitored Person's Name: _____

…for the quarter of: [ ] Jan-Mar *or* [ ] Apr-Jun *or* [ ] Jul-Sep *or* [ ] Oct-Dec 20_____

| | | |
|---|---|---|
| **Medications prescribed to the monitored person, by you, or to your knowledge:** | ☐ ***Yes*** | ☐ ***No*** |
| *Description:* | | |
| **Drug screens conducted by you since last report? Or by others known to you?** | ☐ ***Yes*** | ☐ ***No*** |
| Drug screens conducted at your direction? | ☐ ***Yes*** | ☐ ***No*** |
| Drug screens random & observed? | ☐ ***Yes*** | ☐ ***No*** |
| Drug screens follow chain of custody? | ☐ ***Yes*** | ☐ ***No*** |
| **Any positive drug screen results since last report?** | ☐ ***Yes*** | ☐ ***No*** |
| **Positive drug screen results confirmed?** | ☐ ***Yes*** | ☐ ***No*** |
| *Description:* | *Date(s):* | |
| **Are you aware of any evidence of current substance abuse by the monitored person?** | ☐ ***Yes*** | ☐ ***No*** |
| Description: | | |
| **To your knowledge, is the monitored person currently practicing?** | ☐ ***Yes*** | ☐ ***No*** |
| Description: | | |
| **Do you have concerns about the monitored person's ability to practice safely?** | ☐ ***Yes*** | ☐ ***No*** |
| ***In my opinion, this monitored person uses alcohol or drugs to the extent that such use renders them unsafe to practice, <u>or</u> has a mental or physical illness rendering them unsafe to practice.*** | ☐ *Agree* | ☐ *Disagree* |
| *Description:* | | |
| **Explanations, Questions, Concerns, or Comments** | | |
| | | |
| **Treatment Provider's Signature** | **Date** | |

*Your cooperation is appreciated. If you have any questions, concerns or comments, please feel free to contact the Nursing Compliance Case Manager or to list them above.*