IOWA MONITORING PROGRAM
for Pharmacy Professionals

Quarterly Report – Medical Provider

Participant Name:	**Medical Provider Name and Credentials:**
	Contact Information:

Reporting Quarter:	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
	January-March	April-June	July-September	October-December
	Report due April 20th	Report due July 20th	Report due Oct 20th	Report due Jan 20th

Appointment Date(s):		
Current diagnosis:		
Current medication and reason (prescribed by this medical provider only):		
Has there been a change in the participant's diagnosis and/or treatment? Please explain.	**YES**	**NO**
Does the current diagnosis affect the participant's ability to practice pharmacy? If yes, please explain.	**YES**	**NO**
Do you recommend any changes to the participant's treatment requirements, including the frequency of services, need for re-evaluation, work restrictions, etc.? If yes, please explain.	**YES**	**NO**
Is the participant compliant in treatment (willing participant, attends appointments as scheduled, demonstrates motivation to work towards goals, etc.)? Please explain.	**YES**	**NO**

Question		
Does the participant have insight into their condition? Please explain.	**YES**	**NO**
Has the participant signed releases for you to communicate with their therapist and/or aftercare provider?	**YES**	**NO**
Have you communicated with the participant's therapist and/or aftercare provider this quarter? If yes, please explain.	**YES**	**NO**
Based on your knowledge, is the participant adherent with their IMP3 contract?	**YES**	**NO**
Would you like the IMP3 case manager to contact you?	**YES**	**NO**
SUBSTANCE USE CASES ONLY: **Do you have any concerns about this participant's ability to travel outside the U.S. or to a location where drug screen monitoring is not available during this next reporting period based on his/her status at the time of this report?**	**YES**	**NO**
What is your assessment of the participant's condition and prognosis?		
Comments, Questions, or Concerns:		
SIGNATURE	**DATE**	

Complete this form and return to IMP3 either by email, mail, or fax.

Email: Rebecca.Carlson@iowa.gov

Fax (515) 725-0642

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