IOWA MONITORING PROGRAM
for Pharmacy Professionals

Quarterly Report – Therapist Monitor

Participant Name:	**Therapist Monitor 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):		
Primary focus in treatment:		
Secondary focus in treatment:		
Has progress been demonstrated towards their treatment goals? Please give an explanation.	**YES**	**NO**
What is the current appointment frequency? Do you recommend a change in frequency? Please explain.	**YES**	**NO**
Is the participant compliant in treatment (willing participant, attends appointments as scheduled, demonstrates motivation to work towards goals, etc.)?	**YES**	**NO**

Does the participant have insight into their condition? Please explain.	**YES**	**NO**
Has the participant signed releases for you to communicate with their medical provider(s)?	**YES**	**NO**
Have you communicated with the participant's medical provider this quarter?	**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**
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

Mail to: Board of Pharmacy, Attn: IMP3

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