IOWA MONITORING PROGRAM
for Pharmacy Professionals

Quarterly Report – Aftercare Monitor

Participant Name:	**Aftercare Monitor Name:**
	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

Dates of Group Sessions:		
Dates of Individual Sessions:		
Current Treatment Goals:		
Has progress been demonstrated towards their treatment goals? Please give an explanation.	**YES**	**NO**
Which meetings does the participant attend—AA, NA, Celebrate Recovery, SMART, or other?		
How often does the participant attend self-help meetings?		
Does the participant actively participate in group discussion?	**YES**	**NO**

Does the participant give and receive feedback appropriately?	**YES**	**NO**
Does the participant appear motivated and ask for help?	**YES**	**NO**
Does the participant have insight into their condition?	**YES**	**NO**
Do you recommend a change in the frequency of sessions? If yes, provide recommendation	**YES**	**NO**
Do you recommend any changes to the participant's individual and/or group requirements, including the frequency of self-help meetings, need for re-evaluation, etc.?	**YES**	**NO**
Are the proper supports/requirements in place for monitoring and treatment to promote success?	**YES**	**NO**
Have you communicated with the participant's monitoring 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

400 SW 8th Street, Suite E

Des Moines, IA 50309