Iowa Physician HEALTH PROGRAM

Therapist—Quarterly Report

Complete the form and return to IPHP staff.
400 SW 8th Street, Suite C, Des Moines, IA 50309
www.iphp.iowa.gov.

Participant Name:	**Therapist Name:**

Indicate which quarter this report covers.

- ☐ 1st Quarter (January-March) - due April 1– 20
- ☐ 2nd Quarter (April-June) - due July 1-20
- ☐ 3rd Quarter (July-Sept) - due Oct 1– 20
- ☐ 4th Quarter (Oct-Dec) - due Jan 1– 20

Dates of Therapy Sessions:

What is the primary focus of treatment?

What is the secondary focus of treatment?

Has progress been demonstrated towards his/her treatment goals? ☐ **YES** ☐ **NO**

Is the participant compliant with treatment (willing participant, attends sessions as scheduled, demonstrates motivation to work towards goals, etc.)? ☐ **YES** ☐ **NO**

Does the participant have insight into his/her condition? ☐ **YES** ☐ **NO**

Do you recommend a change in the frequency of therapy sessions? ☐ **YES** ☐ **NO**
If yes, what is your recommendation?

Has there been a change in the participant's diagnosis? ☐ **YES** ☐ **NO**
If yes, please explain.

Does the current diagnosis affect the participant's ability to practice medicine? ☐ **YES** ☐ **NO**
If yes, please explain.

Has the participant signed releases for you to communicate with his/her monitoring physician? ☐ **YES** ☐ **NO**

Have you communicated with the participant's monitoring physician this quarter? ☐ **YES** ☐ **NO**

Based on your knowledge, is the participant adherent with his/her IPHP contract? ☐ **YES** ☐ **NO**

Would you like the IPHP case manager to contact you? ☐ **YES** ☐ **NO**

ADDITIONAL COMMENTS OR CONCERNS:

SIGNATURE: **DATE:**