



Monitoring Physician—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:	Monitoring Physician Name:
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Indicate which quarter this report covers.	
1st Quarter (January-March) - due April 1– 20	3rd Quarter (July-Sept) - due Oct 1– 20
2nd Quarter (April-June) - due July 1-20	4th Quarter (Oct-Dec) - due Jan 1– 20

Dates of Sessions:

Current Diagnosis & Medication (prescribed by monitoring physician):

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

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

Is the participant compliant in 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

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 or aftercare provider this quarter? YES NO

Based on your knowledge, is the participant adherent with their IPHP contract? YES NO

What is your assessment of the participant's condition and prognosis?

Would you like the IPHP 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

ADDITIONAL COMMENTS or CONCERNS:

SIGNATURE:

DATE: