Monitoring Healthcare Provider—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 Healthcare Provider Name:**

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 healthcare provider):

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

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

Do you recommend any changes to the participant's treatment requirements, including the frequency of services, need for re-evaluation, work restrictions, etc.? **YES** **NO**

If yes, explain.

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:**