



Aftercare 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:	Aftercare Provider 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 Group Sessions:

Dates of Individual Sessions:

Current Treatment Goals:

Has progress been demonstrated toward his/her treatment goals?	YES	NO	
Does the participant actively participate in group discussion?	YES	NO	N/A
Does the participant give and receive feedback appropriately?	YES	NO	N/A
Does the participant appear motivated and ask for help?	YES	NO	
Does the participant have insight into his/her condition?	YES	NO	
Does the participant attend self-help meetings weekly?	YES	NO	

Which meetings does the participant attend—AA, NA, Celebrate Recovery, SMART, or other?

Are the proper supports/requirements in place for monitoring and treatment to promote success? YES NO

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

Explain "No" responses to the previous questions on page 1 & 2.

What is his/her overall progress in treatment?

Do you recommend any changes to the participant's aftercare (individual & group) requirements, including the frequency of self-help meetings, need for re-evaluation, etc.? YES NO
If Yes, provide recommendation.

Do you have any concerns about the participant's ability to remain in active practice? YES NO
If yes, please explain.

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

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

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: