IOWA | Department of Inspections, Appeals, & Licensing

# IOWA PROFESSIONAL HEALTH PROGRAMS

## Quarterly Report - Monitoring Healthcare Provider

| Participant Name: | Monitoring Healthcare Provider Name & Credentials: |
|---|---|
| | Contact Information: |

Indicate which quarter this report covers:

☐ 1st Quarter ☐ 2nd Quarter ☐ 3rd Quarter ☐ 4th Quarter

Appointment Date(s):

Current Diagnosis:

List all current medication and reason (prescribed by this medical provider only):

| | YES | NO |
|---|---|---|
| Has there been a change in the participant's diagnosis and/or treatment? If yes, please explain. | ☐ | ☐ |
| Does the current diagnosis affect the participant's ability to practice in the field they are licensed in? If yes, please explain. | ☐ | ☐ |
| 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, please explain. | ☐ | ☐ |
| Is the participant compliant in treatment (willing participant, attends appointments as scheduled, demonstrates motivation to work toward goals, etc.)? Please explain. | ☐ | ☐ |
| Does the participant have insight into their condition? Please explain. | ☐ | ☐ |
| To your knowledge, is the participant adherent with their IPHP contract? | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| Has the participant signed releases for you to communicate with their therapist and/or aftercare provider? | ☐ | ☐ |
| Have you communicated with the participant's therapist and/or aftercare provider this quarter? If yes, please explain. | ☐ | ☐ |
| SUBSTANCE USE CASES ONLY: Do you have any concerns about this participant's ability to travel outside of the U.S. or to a location where drug screen monitoring is not available during this next reporting quarter based on their status at the time of this report? | ☐ | ☐ |
| To your knowledge, has the participant experienced a return to use during this quarter? | ☐ | ☐ |
| What is your assessment of the participant's condition and prognosis? | | |
| Would you like the IPHP staff to contact you? | ☐ | ☐ |
| Any further Comments, Questions or Concerns? | | |
| Monitoring Healthcare Provider's Signature: Date: | | |

## PROGRAM CONTACTS:

*Department of Inspections, Appeals, & Licensing*
*ATTN: IPHP*
*6200 Park Avenue Suite 100*
*Des Moines, 50321-1270*

**Medicine**

Natalie Lyons
Program Coordinator
Fax: (515) 242-0155
natalie.lyons@iowa.gov

Alison Brown
Program Case Manager
Fax: (515) 242-0155
alison.brown@iowa.gov

**Dental, Pharmacy, Professional Licensure**

Becky Carlson
Program Coordinator
Fax: (515) 725-0642
rebecca.carlson@iowa.gov

Crystal Walker-Smith
Program Case Manager
Fax: (515) 725-0642
crystal.walker-smith@iowa.gov

**Nursing**

Katie Barry
Program Case Manager
Fax: (515) 725-4017
katie.barry@iowa.gov