



# IOWA PROFESSIONAL HEALTH PROGRAMS

## Quarterly Report - Aftercare Provider

Participant Name:	Aftercare Provider Name and Credentials:
	Contact Information:

Indicate which quarter this report covers:

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

Dates of Group Sessions:

Dates of Individual Sessions:

Current Treatment Goals:

	Yes	No
Has progress been demonstrated toward their treatment goals?	<input type="checkbox"/>	<input type="checkbox"/>
Does the participant actively participate in group discussion?	<input type="checkbox"/>	<input type="checkbox"/>
Does the participant give and receive feedback appropriately?	<input type="checkbox"/>	<input type="checkbox"/>
Does the participant appear motivated and ask for help?	<input type="checkbox"/>	<input type="checkbox"/>
Does the participant have insight into their condition?	<input type="checkbox"/>	<input type="checkbox"/>
Does the participant attend self-help meetings weekly?	<input type="checkbox"/>	<input type="checkbox"/>
Did the participant experience a return to use during this quarter?	<input type="checkbox"/>	<input type="checkbox"/>

Please provide an explanation for your responses above:

Which meetings does the participant attend? AA, NA, Celebrate Recovery, SMART or other? How often?		
	Yes	No
Do you recommend a change in the frequency of sessions? If yes, please provide recommendation.	<input type="checkbox"/>	<input type="checkbox"/>
Do you recommend any changes to the participant's individual and/or group requirements, including frequency of self-help meetings, need for re-evaluation, etc? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
Are the proper supports/requirements in place for monitoring and treatment to promote success? Please explain.	<input type="checkbox"/>	<input type="checkbox"/>
Have you communicated with the participant's monitoring healthcare provider this quarter?	<input type="checkbox"/>	<input type="checkbox"/>
Based on your knowledge, is the participant adherent with their IPHP contract?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like the IPHP staff to contact you?	<input type="checkbox"/>	<input type="checkbox"/>
Any further Comments, Questions or Concerns?		
Aftercare Provider's Signature:		Date:

**PROGRAM CONTACTS:**

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