Maryland Professional Rehabilitation Program

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Baltimore, MD 21201-5512
Phone: 410.878.9843
Fax: 410.878.9538

REPORTING SCHEDULE (CHECK)

March 31 _____
June 30 _____
September 30 _____
December 30 _____

PARTICIPANT:_____

REPORTER: _____

CONTACT (CIRCLE:) INDIVIDUAL TX GROUP TX. OTHER TX._____

CURRENT FREQUENCY _____/ _____MONTH _____/_____MONTH _____/_____MONTH

1. NUMBER OF SCHEDULED SESSIONS WITHIN REPORTING PERIOD: #_____

2. SCHEDULED SESSIONS MISSED WITHIN REPORTING PERIOD: #_____LIST REASON(S)

3. PLEASE DESCRIBE THE GOALS OF YOUR CURRENT TREATMENT AND PROGRESS MADE SINCE THE LAST REPORTING PERIOD.

4. IF ANY, PLEASE INDICATE NUMBER OF URINE SCREENS WITHIN REPORTING PERIOD: #_____
ALL NEGATIVE ____ IF POSITIVE URINE SCREEN, LIST DATE, DRUG(S) AND ACTION TAKEN.

PLEASE PROVIDE YOUR CLINICAL ASSESSMENT AND COMMENT REGARDING THE FOLLOWING FOR THIS REPORTING PERIOD:

	POOR				EXCELLENT
5. VOCATIONAL (COMMENTS AND RECOMMENDATIONS)	1	2	3	4	5
6. RELATIONSHIPS/FAMILY (COMMENTS AND RECOMMENDATIONS)	1	2	3	4	5
7. PERSONAL WELLBEING (COMMENTS AND RECOMMENDATIONS)	1	2	3	4	5
8. HEALTH STATUS (COMMENTS AND RECOMMENDATIONS)	1	2	3	4	5
9. OVERALL (COMMENTS AND RECOMMENDATIONS)	1	2	3	4	5

10. IS THIS CLIENT PRESENTLY EXPERIENCING ANY PROBLEMS THAT YOU BELIEVE MAY NEGATIVELY IMPACT THEIR ABILITY TO SAFELY PRACTICE MEDICINE? PLEASE EXPLAIN.

11. ADDITIONAL COMMENTS (USE SEPARATE SHEET AS NECESSARY):

SIGNATURE:_____ DATE:_____

PLEASE RETURN THIS FORM BY FAX OR MAIL USING THE INFORMATION LISTED ABOVE.

PLEASE NOTIFY THE PHYSICIAN REHABILITATION PROGRAM WITHIN 24 HOURS OF ANY OF THE FOLLOWING:

1) A positive toxicology screen; 2) Appearing to be imminent danger to self or others; 3) Being subject to any disciplinary actions or investigations; 4) Changes in hospital or healthcare facility privileges; or 5) Changes in employment.

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