

Center for a Healthy Maryland
 Maryland Physician Health Program
TREATMENT REPORT

REPORTING SCHEDULE

PHYSICIAN CLIENT: _____

BIMONTHLY _____
 MONTHLY _____
 QUARTERLY _____
 SEMI-ANNUAL _____
 DUE DATE _____

REPORTER: _____

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

FREQUENCY _____/ MONTH, _____/ MONTH _____/ MONTH

1. SCHEDULED SESSIONS MISSED WITHIN REPORTING PERIOD: # _____ REASON(S)

2. PLEASE DESCRIBE GOALS OF CURRENT TREATMENT AND PROGRESS MADE SINCE LAST REPORTING PERIOD.

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

PLEASE ASSESS THE FOLLOWING ACCORDING TO YOUR CLINICAL KNOWLEDGE FOR THIS REPORTING PERIOD AND COMMENT AS APPROPRIATE.

	POOR			EXCELLENT	
4. VOCATIONAL	1	2	3	4	5
5. RELATIONSHIPS	1	2	3	4	5
6. PERSONAL	1	2	3	4	5
7. HEALTH STATUS	1	2	3	4	5
8. OVERALL	1	2	3	4	5

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

10. ADDITIONAL COMMENTS (USE SEPARATE SHEET AS NECESSARY)

SIGNATURE: _____ DATE: _____

PLEASE NOTE: REGARDING THIS CLIENT, PLEASE NOTIFY THE PHYSICIAN HEALTH PROGRAM WITHIN 24 HOURS OF ANY OF THE FOLLOWING:

- 1) A positive toxicology screen. 2) Appearing to be a danger to self or others. 3) Intent to harm self or others. 4) Being subject to any disciplinary actions or investigations. 5) Changes in hospital or healthcare facility privileges. 6) Changes in employment.