PARTICIPANT DEMOGRAPHIC & INTAKE FORM

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Full Name of Prospective Participant (Please attach your CV)

Last: _____ First: _____Middle: _____

Date of Birth: _____ SS#: _____

Degree: MD DO PA OTHER _____Specialty _____

Spouse/Significant Other: _____

Home Address:

Street _____

City _____ State _____ Zip _____ County _____

Office Address:

Street _____

City _____ State _____ Zip _____ County _____

I prefer to receive NDPHP correspondence at my _____ home address _____ office address

Phone: Home_____ Cell_____
Office_____ Pager_____
Email: _____

Medical License number(s) and status of license(s): *(Use reverse if additional space is needed.)*

State_____ Number_____ Status_____
State_____ Number_____ Status_____
State_____ Number_____ Status_____

Primary Care Physician:

Name _____ Degree MD DO

North Dakota Professional Health Program
tel 701.751.5090 *fax* 701.751.7518 ndphp.org
919 S 7th St. Suite 305 Bismarck, ND 58504

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Address where NDPHP correspondence for PCP is to be mailed:

Street _____

City _____ State _____ Zip _____ County _____

Phone: _____ Email Address _____

Monitor: (Please attach Monitor's CV) *(if applicable.)*

Name _____ Degree MD DO

Address where materials and correspondence for Monitor are to be mailed:

Street _____

City _____ State _____ Zip _____ County _____

Phone: _____ Email Address _____

Past and/or Present Medical Board, Court System, State or Hospital Monitoring Program involvement: *(use reverse if additional space is needed.)*

Name _____

Contact Person _____

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

Name _____

Contact Person _____

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

Name _____

Contact Person _____

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

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Medical Liability Insurance Information:

Name _____

Attorney (if applicable):

Name _____

Contact Person _____

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

MEDICATION RECORD

No.	Medication	Dosage	Purpose	Prescribing Physician
1				
2				
3				
4				
5				

(Use separate page if additional space is needed.)

Past or Present Treatment Program(s): *(Use separate page if additional space is needed.)*

Drug(s) of abuse (include all) _____

Sobriety Date _____

Name _____

Admission/Discharge Dates _____

Contact Person _____

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

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Name _____

Admission/Discharge Dates _____

Contact Person _____

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

Past (within 10 years) and/or Present Therapist(s): *(Use separate page if additional space is needed.)*

Name _____ Degree/Credentials _____

Street _____

City _____ State _____ Zip _____ County _____

Phone: _____ Email Address _____

Treatment Date(s) _____

Purpose _____

Name _____ Degree/Credentials _____

Street _____

City _____ State _____ Zip _____ County _____

Phone: _____ Email Address _____

Treatment Date(s) _____

Purpose _____

Any additional person/organization that you think would be beneficial or necessary for NDPHP to contact on your behalf: *(Use separate page if additional space is needed.)*

Name _____

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

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Name _____

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

Name _____

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

I am presently employed _____ Unemployed _____

I am _____ a resident _____ a solo practitioner _____ in a group practice _____ an employee

I found out about NDPHP from _____

-or-

I was referred to NDPHP by _____

_____ _____

Signature Date

**** Please attach copies of any medical board, court, monitoring or treatment records, especially assessment and discharge summary/recommendations you may have in your possession. If these are available to you, please contact the facility or agency and request that your records be forwarded to NDPHP.****

Comments or questions:

_____

_____

_____

_____

_____

Thank you,

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PARTICIPANT DEMOGRAPHIC & INTAKE FORM

I, _____, agree to undergo a **complete medical, psychiatric, and/or chemical dependency evaluation and/or treatment** at an appropriate facility approved by the North Dakota Professional Health Program (NDPHP). I understand that I am responsible for all expenses related to the evaluation and/or treatment and elect to have the evaluation performed at:

_____

(Name and Address of Facility)

I agree to report for the evaluation within seventy-two (72) hours, unless other arrangements are made and approved by the NDPHP. I agree to cooperate fully with the evaluation process including identifying and providing consent for communication with individuals able to provide collateral information regarding my history. In the event treatment is required, I agree to attend a treatment facility approved by the NDPHP.

I hereby authorize on-going direct communication between the Medical Director, Executive Director and authorized staff of the NDPHP and the staff of the evaluation/treatment facility to discuss my medical and substance abuse history, results of my evaluation and treatment recommendation, if any, and to receive copies of individual assessments until I either revoke this consent or it expires on the date listed below. This communication is required to facilitate clarification of my psychiatric or substance abuse related diagnosis. This consent is subject to revocation at any time, except to the extent that the program, which is to make the disclosure, has already taken action in reliance upon it. Revocation of this release prior to completion of my evaluation/treatment will be interpreted as non-compliance with the terms of NDPHP participation. I will sign release of information forms, as necessary, at my treatment facility so that my healthcare providers can speak with the NDPHP representatives.

I authorize the Medical Director, Executive Director or authorized staff of NDPHP to communicate information regarding the evaluation, treatment recommendations or treatment as well as their own support needs, directly with;

_____
_____
_____
_____

(Name: Spouse or significant other / other family members)

_____
_____
_____
_____

(Name: Partners / practice associates / office staff / hospital representative / referent / other)

I understand that my records are protected by State and Federal (42 CFR Part 2) Confidentiality Laws which prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I agree to abide by the terms of this agreement until I am placed under Voluntary Agreement with the NDPHP or am released from their province. I understand that failure to comply with this agreement will be reported to my ND Licensing Board.

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I hereby provide consent for NDPHP to release any and all records in its files about my evaluation, treatment recommendations and treatment to my appropriate Licensing Board should I fail to comply with the terms of this agreement.

Date upon which this consent will expire if not revoked before; this date ensures that the consent will last no longer than reasonably necessary to serve the purpose for which it is given: Expiration Date: _____

_____ _____
Participant Name (Printed) & Signature Date

_____ _____
Witness Name (Printed) & Signature Date

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