



PRIMARY CARE PROVIDER REPORT FORM

You have been asked to monitor the progress of one of our participants,
we ask that you please submit this form quarterly to the address below.

Your partner in the process

NDPHP Licensee Name: _____

Date of appointment(s): _____

Please check the answer to each of the following questions

- | | | | |
|--|---|---|----|
| 1. Does the participant report clear thought processes and functions? | Y | N | NA |
| 2. Does the participant appear actively involved in the appointment? | Y | N | NA |
| 3. Is your patient abstinent and practicing recovery behaviors (if appropriate)? | Y | N | NA |

Please explain any "No" responses:

Please check the answer to each of the following questions:

- | | | | |
|---|---|---|----|
| 4. Have there been any changes in diagnosis or treatment? | Y | N | NA |
| 5. Have you recommended any changes to their medications -
over the counter and/or prescription? | Y | N | NA |
| 6. Based on what you know about this participant, do you have any new concerns
that might indicate this participant may be unable to practice medicine safely? | Y | N | NA |

Please explain any "YES" responses:

Would you like the NDPHP to call you regarding this participant? _____ Yes _____ No

Primary Care Provider's Signature

Date

Primary Care Provider's Name (printed)

Phone