



BEHAVIORAL HEALTH 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.

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. Have there been any changes in diagnosis or treatment? | Y | N | NA |
| 4. Have you recommended any changes to their medications - over the counter and/or prescription? | Y | N | NA |
| 5. 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:

Recommended Frequency of Follow-Up Appointment (s) _____

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

Behavioral Health Provider's Signature

Date

Behavioral Health Provider's Name (printed)

Phone