# 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:**

_____
_____
_____

**Recommended Frequency of Follow-Up Appointment (s)** _____
_____

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

North Dakota Professional Health Program
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