TAPNET PARTICIPANT SELF REPORT

DATE:_____

CASE #/MGR.: _____

INSTRUCTIONS: Complete this form and mail the original to TAPNET at the address below by the 10th of each month along with your TAPNET MONTHLY ATTENDANCE RECORD. **Please remember you are completing this form for the previous month.**

Name (Print): _____

Address: _____

City:_____ **State:**_____ **Zip:** _____

Phone:_____ **Work:**_____ **Cell:**_____

E-mail:_____

☐ **Check if this is a new address and/or phone numbers**

ARE YOU CURRENTLY EMPLOYED? Counseling_____ Non-Counseling_____ Unemployed _____

PLACE OF EMPLOYMENT: _____

FOR ALL PARTICIPANTS

1. List all current prescription and over the counter medications:

Name of Medication	Prescribed by:	Date Prescribed:

2. Did your physician(s) send TAPNET the updated TAPNET Prescription Information form for the above?
   Y____N____No chances____If not sent, will send on (date): _____
3. What requests do you have of TAPNET at this time? _____
   _____
4. How is participating in TAPNET benefiting you? _____
   _____If you are not benefiting, what would help? _____
   _____
5. What major changes have occurred in your life this month? _____
   _____
   _____
6. What are you doing to take care of yourself? _____
   _____
   _____
7. Who is your TAPNET Advocate?_____Advocate's Phone #: _____
   How many times have you seen your Advocate this month? _____
   How many times have you spoken with your Advocate by phone this month? _____

FOR SUBSTANCE ABUSE/ DEPENDENCY

1. How many AA meetings per week are you attending?_____What step are you working?_____
   What does this step mean to you? _____
   _____
   _____
2. Your 12 step sponsor's first name?_____How often do you contact your sponsor?_____
   When is the last time you met with your sponsor? _____
3. Are you still attending aftercare? Y___N____if yes, has your treatment provider sent a progress report? Y____N ____
4. Describe your current treatment plan: _____
   _____
5. Name of your psychiatrist:_____Dates seen this month: _____
6. Name of your therapist:_____Dates seen this month: _____

Signature_____**Date**_____

Case #_____**Case Manager** _____

FOR PSYCHIATRIC AND DUAL DIAGNOSIS

NOTE: WRITE N/A IF NOT APPLICABLE OR IF ALREADY ANSWERED IN PREVIOUS SECTION

1. Date discharged from inpatient, day hospital, or intensive outpatient program: _____
   Name/Location of facility: _____
2. Have you sent your prescription info/ Progress Report since your last appt? _____
3. Describe your current treatment plan: _____
   _____
4. Name of your psychiatrist:_____Dates seen this month: _____
5. Name of your therapist:_____Dates seen this month: _____

Signature_____**Date**_____

Case #_____**Case Manager** _____

Please use the space below for any additional comments or information.