TEXAS PEER ASSISTANCE PROGRAM FOR NURSES

Patient/Nurse's Name: _____

Date: _____ Case # _____

PARTICIPANT MEDICATION REPORT FORM

(quarterly submission required)

DIRECTIONS: To be completed and signed by prescribing clinician, then returned to TPAPN by fax, mail or secure email.

MEDICATION INFORMATION (prescription and non-prescription)

Date Prescribed	Medication/Dose	Quantity Prescribed	Refills	Diagnosis/Reason for Medication

Please use multiple pages of this form is needed to list all medications.

PRESCRIBING CLINICIAN QUESTIONNAIRE

1. Did this nurse inform you that he/she is in recovery, participating in TPAPN, and has a substance use and/or mental health condition?

2. Did this nurse inform you of his/her substance use and/or mental health history, including drug(s) of choice? If so, please briefly describe below:

3. Have you reviewed all the background provided to you by this nurse's TPAPN Case Manager (if applicable)?

4. If prescribing opioids, are your prescribing practices consistent with current best practices?
   - CDC Guidelines for Prescribing Opioids for Chronic Pain
   - ACOEM Guidelines: Opioids and Safety-Sensitive Work
   - The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use

5. Please describe in detail what options were utilized for managing the condition(s) or symptom(s) before resorting to the current medication being prescribed:

6. Did you talk with the nurse about the potential risks of this medication and how that may jeopardize his/her recovery?

7. How long do you anticipate this nurse will need to take this/these medications?

8. Are you ABAM or ABPN certified in addiction? Yes or No

9. How can the source of the condition or pain be addressed, rather than just the symptoms? What is the long-term plan?

10. Please describe any prescription history concerns after your review of the Prescription Monitoring Program (PMP) for this nurse. If you did not review the PMP, please detail why you didn't feel a review was appropriate:

11. Do you feel that this nurse is safe to practice nursing while taking this and/or these medication(s): Yes or No

CLINICIAN INFORMATION

Clinician's Name: _____ Clinician's Credentials: _____

Name of Facility/Practice: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____ Email: _____

Prescribing Clinician's Signature _____**Date**_____