TEXAS PEER ASSISTANCE PROGRAM FOR NURSES

Patient/Nurse's Name: _____

Date: _____ Case # _____

PARTICIPANT MEDICATION REPORT FORM

DIRECTIONS: To be completed and signed by **prescribing clinician**, then returned to TPAPN by fax, mail or secure email (quarterly submission required).

MEDICATION INFORMATION (prescription and non-prescription) Please use multiple pages of this form if needed to list all medications.

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

PRESCRIBING CLINICIAN QUESTIONNAIRE

1. **Initial Encounter Only** (not required to answer if previously submitted): Did this nurse inform you that he/she is in recovery, participating in TPAPN, and has a substance use and/or mental health condition?
   Yes ____ No ____

2. 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 _____
   - Not prescribing opioids (not applicable) ____

3. If prescribing medication(s) with abuse potential/risk (Schedule II-V drugs); and, considering the individual's history, substance use and/or mental health diagnosis and safety sensitive profession, were non-mood-altering methods of treatment explored? Yes ____ No ____ N/A ____

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

5. Was a review of the Prescription Monitoring Program (PMP) conducted for this nurse? If not, please provide reason:

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

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

ABAM or ABPN certified in addiction? Yes ____ No ____ Name of Facility/Practice: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____ Email: _____

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