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.

<table>
<thead>
<tr>
<th>Date Prescribed</th>
<th>Medication/Dose</th>
<th>Quantity Prescribed</th>
<th>Refills</th>
<th>Diagnosis/Reason for Medication</th>
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**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 ____________

   Program of the Texas Nurses Foundation | In cooperation with the Texas Board of Nursing
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