Nurse's Name: _____

Date: _____ Case # _____

PARTICIPANT THERAPIST REPORT FORM

(monthly submission required)

DIRECTIONS: To be completed and signed by nurse's therapist, then returned to TPAPN by fax, mail or secure email.
Please attach a copy of the Treatment Plan and notes/updates related to the treatment plan.

This Reports covers the following time period: FROM (date) _____ TO (date): _____
The number of visit during this time period were: _____
Has the nurse attended appointments as scheduled? YES / NO
If not, please explain in detail (i.e., why not, were missed appointments reschedule, how resolved).

Is this nurse engaged in treatment? YES / NO
If not, why?

Treatment goals progress:

Mental status assessment:

Alcohol and/or substance use assessment:

Do you have concerns about this nurse's ability to perform the following work place tasks:

• Think critically, plan, organize, and prioritize:	☐ Yes	☐ No
• Remember and concentrate:	☐ Yes	☐ No
• Communicate effectively with healthcare team members:	☐ Yes	☐ No
• Develop and maintain a therapeutic provider-patient relationship:	☐ Yes	☐ No
• Respond appropriately to emergencies in the workplace:	☐ Yes	☐ No

If "Yes," please explain:

The above-named nurse **does not** have a physical, emotional, or psychological problem which renders him/her unstable to practice as a nurse with reasonable skill and safety.

☐ Agree ☐ Disagree

The above-named nurse **does not** exhibit addiction behavior and/or patterns of behavior which may impair his/her ability to practice in the licensed profession with reasonable skill and safety.

☐ Agree ☐ Disagree

If disagree, please explain:

Additional comments:

THERAPIST INFORMATION

Therapist's Name: _____ Therapist's Credentials: _____

Name of Facility/Practice: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____ Email: _____

Therapists' Signature _____**Date**_____