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 report covers the following time period: FROM (date) __________________ TO (date): __________________
The number of visits 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 workplace 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 ______________