PARTICIPANT THERAPIST REPORT FORM
(monthly submission required, due by the 10th of each month)

DIRECTIONS: To be completed and signed by nurse’s therapist, then returned to TPAPN by fax 512-467-2620, secure email or mail
Please attach a copy of the Treatment Plan and notes/updates related to the treatment plan

Nurse’s Name: _________________________
Date: ______________                                                                                                                               Case # ________________

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 rescheduled, how resolved)

Date of next scheduled appointment: __________

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

Treatment goals progress:

Mental status assessment:

Alcohol and/or drug use reported? YES NO
If yes, please explain:

Do you have concerns about this nurse’s ability to perform the following workplace tasks:

<table>
<thead>
<tr>
<th>Task</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Think critically, plan, organize, and prioritize:</td>
<td></td>
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<tr>
<td>Remember and concentrate:</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Communicate effectively with healthcare team members:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Develop and maintain a therapeutic provider-patient relationship:</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Respond appropriately to emergencies in the workplace:</td>
<td>Yes</td>
<td>No</td>
</tr>
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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 ____________