Mississippi Physician Health Program

Psychiatrist/Therapist Report
(Personal and Confidential)
Quarterly Progress Report

From: _____
Psychiatrist/Therapist Name (Printed)

March – June – September - December
(please circle one)

Re: _____
Physician Name (Printed)

Case Manager: Kristin A. Powell, LCSW
Associate Director
Ph: 601-420-0240 Ext. 105

MPHP has the above physician's consent to request reports from you on a periodic basis. **Your report is crucial to this person's contract compliance.** In order to facilitate the reporting process, we ask that you fill out the information below and **submit via email to** kpowell@ms-php.prg **or fax to Kristen Powell, LCSW at fax number, 601-499-1224**. Thank you.

Diagnosis:	
Treatment plan and number of visits this quarter:	
Current Medication:	
Compliance/Commitment:	
Fitness for Duty:	
Additional Comments:	

MPHP wishes to respect the Doctor/Patient relationship, however, we make program participants aware that their psychiatrist/therapist is asked to call us if: 1) a chemically dependent patient is in relapse; 2) there is a potential risk to the public; and/or 3) in the therapist's opinion, the participant is unable to practice with reasonable skill and safety.

Would you like for a representative of MPHP to contact you? Yes __ No __

If yes, please provide your phone number: _____

_____ _____
Psychiatrist/Therapist Signature Date

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www.ms-php.org