



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: Amanda Freeman, LMSW
Ph: 601-420-0240 Ext. 106

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 afreeman@ms-php.org or fax to Amanda Freeman, LMSW at fax number, 769-567-2080.** 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