



Addictionologist/Mental Health Provider Report Form

To: PRN Social Worker
3200 Steck Ave. Suite 370
Austin, TX 78757
Fax: (512) 836-0308

From: _____
Addictionologist/Mental Health Provider's Name, Address, Phone #

Re: _____
Name of PRN Participant

Date: _____

The following information is supplied with the above-named participant's consent:

I have been informed that this participant is being monitored by the Professional Recovery Network (PRN) for:

- Substance Abuse/Dependence Disorder
- Psychiatric Disorder
- Both

Date of First Visit: _____ Date of Last Visit: _____ Frequency of Visits: _____

Diagnoses: _____

Medications I have prescribed or am monitoring:

- Unchanged (previously documented)
- Initial report, new, or change in prescription

Date of Prescription	Medication	Dosage/Quantity/Refills
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



Participant's compliance with my treatment recommendations:

- Completely in compliance
- Partially in compliant for the following reason(s): _____
- Resistant, but resistance issues are minor and a continuing focus in therapy
- Resistant for the following reason(s): _____

Addictionologist's/Mental Health Provider's Plan for follow-up:

- Medication Management
- Psychotherapy
- Both

Date of Next Visit: _____

Statement of safety to practice concerning the presence of impairment due to psychiatric/substance abuse or dependence disorder(s):

Based on my current evaluation and clinical opinion,

- I do**
- I do not**

believe the participant possesses the skill and competence to practice his/her profession without posing a risk to him/herself or others based on diagnosis listed above.

Signed,

Signature of Addictionologist/MHP Date

Printed Name