State of Minnesota

Health Professionals Services Program

HPSP, 1380 Energy Lane, Suite 202, Saint Paul, MN 55108 Phone: (651) 643-2120 Fax: (651)643-2163

TREATMENT PROVIDER REPORT FORM

HPSP Participant Name:

Primary TX Focus:

Secondary TX Focus:

Please indicate which quarter this Report Covers:

1/15 ◯ 4/15 ◯ 7/15 ◯ 10/15 ◯

# of visits during quarter: **Year:**

Symptoms:
(i.e.: current, active, changes, exacerbations, relapse?

Medications:

To the best of your knowledge, is the client/patient currently working in their licensed profession? ◯ **YES** ◯ **NO**

To the best of your knowledge, has the client/patient changed jobs since the last reporting period? ◯ **YES** ◯ **NO**

Treatment Plan/ Recommendations/ Interventions:

Practice Restrictions (if any):

Client/Patient Insight:

Agency Name:

Provider Name:

Provider Phone Number:

Date Report Completed:

Please PRINT out the completed form, SIGN it, and MAIL or FAX it to HPSP.
Thank you for your assistance!

Print Form

Treatment Providers Signature _____

form updated 10/01/2013