revised 10/12

Missouri Physicians Health Program

MONITORING-MENTAL HEALTH GROUP

GROUP ATTENDANCE

Missouri REGION _____
DATE_____

Participant Name _____ MSMA member? Y N

Have your monitoring requirements ever included seeing a therapist or psychiatrist ___yes ___no.

Are you currently seeing a therapist or psychiatrist ___yes, ___no. **If yes,** please provide information below.
Therapist Name_____/number of sessions_____per week/month (cirlcle)
Psychiatrist Name_____/number of sessions_____per week/month (cirlcle)

Current Medications _____
_____
Medication Changes: _____
_____

*I have provided documentation from my primary care physician of the need for these medications and provided copies of prescriptions/**refills** for scheduled medications including (Ambien and Tramadol) to the MPHP Program. Yes___ No___*

Please provide **ANY changes** in the following ***since last meeting***:
Home Address _____ Home Phone Number _____
_____ Home Fax Number _____
_____ Home E-Mail _____
_____ Cell Phone _____

Work Address _____ Work Phone Number _____
_____ Work Fax Number _____
_____ Work E-Mail _____
_____ Exchange/Beeper _____
Please identify the next best way to contact you _____
Who should we contact in case of emergency_____Phone _____

Please list any signlficant issues or concerns you may have._____
_____
_____
_____
_____

*PARTICIPANT SIGNATURE*_____

FACILITATOR/STAFF COMMENTS:_____
_____
_____
_____
_____