revised 4/13

Missouri Physicians Health Program

RECOVERY GROUP MONITORING

Attendance Form

CIRCLE REGION: STL COLUMBIA/MACON SPRFLD KC JOPLIN POP-BLUFF

TODAYS DATE_____

Participant Name _____

Please provide the number of times you attended **SINCE LAST GROUP.**
AA/NA meetings _____per week Caduceus _____per week
Frequency of sponsor contact _____per week

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 (circle)
Psychiatrist Name_____/number of sessions_____ _____per week/month (circle)

Current Medications _____
_____
Medication Changes: _____
_____

*I have provided copies of prescriptions/**refills** for scheduled medications including (Ambien and Tramadol) to the MPHP Program. Yes___ No___*

IF any changes have occurred *SINCE LAST MEETING* (leave blank if no changes) please fill out:

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 best way to contact you _____
Who should we contact in case of emergency_____Phone _____

Have you relapsed? Y N Have you notified MPHP? Y N

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

*PARTICIPANT SIGNATURE*_____

FACILITATOR/STAFF COMMENTS:_____
_____
_____
_____