New Hampshire
Professionals Health Program

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CONFIDENTIAL TREATMENT REPORT

NHPHP Participant: _____ **Date:** _____

This participant has authorized you to provide confidential quarterly reports regarding compliance with a monitoring agreement with the New Hampshire Professionals Health Program (NHPHP). Accurate and prompt information from treatment providers is essential to confirm that your patient is continuing your required treatment and practicing without impairment. Please notify us at above number immediately if treatment is terminated or if you have any questions.

Quarter ending: (please circle) March 31 June 30 September 30 December 31

1) During the past three months, I have met with this participant ____ times at a frequency of _____. What is your planned frequency for the next quarter? _____
Were the appointments frequently rescheduled? No shows? Late? No___ Yes___
Details:

2) Is there any evidence of non-compliance with the NHPHP contract or worrisome behavior? No __ Yes___ Details of concerns or comments:

3) Is there any lack of cooperation or refusal of your treatment recommendations? None / Yes ___
Details:

4) Do you have any concerns regarding the ability to safely practice his or her role in medicine?
No___Yes ___ Details:

5) Have you observed a change in his/her stress, attitude, energy level or appearance? No___ Yes ___
Details:

6) Other concerns:

Would you like the NHPHP Director to call you? No ___ Yes (phone # _____)

_____ _____ _____
Treatment Provider **Signature** **Date**

Address_____**Telephone**_____

Email address:

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