Mississippi Physician Health Program

Psychiatrist/Therapist Report
(Personal and Confidential)
Quarterly Progress Report

From: ____ **March – June – September - December**
Psychiatrist/Therapist Name (Printed) (circle one)

Re: ____ Kristin Wallace, LMSW
Physician Name (Printed) 601-420-0240 ext 102

MPHP has the above physician's consent to request reports from you on a periodic basis. **Your report is crucial to this person's contract compliance.** In order to facilitate the reporting process, we ask that you fill out the information below and **return it to Kristin Wallace, LMSW 601-707-3793** Thank you.

DIAGNOSIS:	
TREATMENT PLAN:	
CURRENT MEDICATION:	
COMPLIANCE/COMMITTMENT:	
FITNESS FOR DUTY:	
ADDITIONAL COMMENTS:	

MPHP wishes to respect the Doctor/Patient relationship, however, we make program participants aware that their psychiatrist/therapist is asked to call us if: 1) a chemically dependent patient is in relapse; 2) there is a potential risk to the public; and/or 3) if, in the therapist's opinion, the participant is unable to practice with reasonable skill and safety.

Would you like for a representative of MPHP to contact you? Yes ___ No ___

If yes, please provide your phone number: ____________________________________

____ ____________________________________
Psychiatrist/Therapist Signature Date

601-707-3793
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