NEW MEXICO MONITORED TREATMENT PROGRAM

CONTROLLED MEDICATION PROVIDER REPORT

Confidential

Participant Name_____Reporting Month_____

Provider_____Phone _____

The individual listed above is a health care provider being evaluated and/or monitored by the New Mexico Monitored Treatment Program. The New Mexico Monitored Treatment Program requires clinical information as part of the individual's assessment process and his/her rehabilitation and monitoring plan. This individual has informed us that you are prescribing controlled medications to him/her. Therefore, please respond to the following questions:

What controlled medications are you currently prescribing for this individual?

MEDICATION NAME	DOSAGE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is the diagnosis that requires treatment with a controlled medication?

What other treatments have been attempted?

What were the outcomes of these treatments?

Is treatment with a controlled medication the only effective treatment for the individual's condition? (If yes, please explain.)

How long to you anticipate that the individual will need to use this medication?

11930 Menaul N.E., Suite 110
Albuquerque, New Mexico 87112
www:monitoredtreatment.com
Phone: (505) 271-0800
Fax: (505) 275-6646
Email: mtp@monitoredtreatment.com

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Is there any evidence of controlled medication abuse? (If yes, please list evidence.)

Are current controlled medications interfering in any way with the individual's ability to work in his/her profession and/or his/her over all functioning?

Has the individual informed you that he/she has a substance abuse disorder or a past history of problems associated with the use of controlled medications?

Have you discussed the long term consequences of the use of this controlled medication with the individual?

Additional comments:

_____ _____

Healthcare Provider Printed Name Healthcare Provider Signature

_____ _____

Telephone Number Date

Provider: Please mail or fax this form to the New Mexico Monitored Treatment Program (address/fax below)

( )Client initial **I give my consent, by my signature below, to allow MTP and my healthcare provider to exchange information regarding my health issues and medications, as deemed necessary by MTP for purposes of monitoring and compliance.**

_____ _____ _____

Client Printed Name Client Signature Date

*The **New Mexico Monitored Treatment Program (MTP)** is a non profit (501c3) board-Governed state wide agency that provides confidential evaluation, treatment referral and monitoring of health care professionals with substance abuse, mental health, behavioral, medical and professional practice issues for the purpose of occupational rehabilitation. In addition, MTP provides education, consultation, and reporting to a variety of agencies, employers and licensing boards.*

Jon Thayer RN, MA, CARN Executive Director; Kate Woods LMFT; LADAC Clinical Coordinator;
Daniel Collins M.D. Medical Director

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