NEW MEXICO MONITORED TREATMENT PROGRAM

PSYCHIATRIC PROVIDER CLINICAL ASSESSMENT AND TREATMENT PLAN REPORT: To be submitted ***by participant*** to MTP after each psychiatric appointment.

Participant Name:_____ Reporting Period_____

Psychiatrist's Name:_____Phone_____

As a psychiatric treatment provider for an MTP participant your clinical assessment and treatment plan information is a necessary part of MTP's ability to understand and monitor this individual. Please fill out the requested information as completely as possible.

Short summary of the patient's significant problems/symptoms:

DSM IV Diagnostic Assessment	**Medications**
Axis I _____	_____
Axis II _____	_____
Axis III _____	_____
Axis IV _____	_____
Axis V _____	_____

What are the goals for psychiatric treatment?

What is the Treatment Plan?

What is the individual's prognosis?

Is participant benefiting from psychiatric treatment?
( ) Yes
( ) No (please explain

Is the individual compliant with treatment?
( ) Yes
( ) No (please explain)

Additional comments:

_____ _____
Psychiatric Provider Signature Date

2500 Louisiana Blvd. NE Suite 250
Albuquerque, New Mexico 87110
www:monitoredtreatment.com
Email: mlgriffin@monitoredtreatment.com
Phone: (505) 271-0800
Fax: (505) 884-4092