

Pu'ulu Lapa'au
Hawai'i Program for Healthcare Professionals
TREATMENT PROVIDER REPORT

Participant Name: Reporting Date:

Treatment provider name: Phone:

Provider role: ☐ Psychiatrist ☐ Psychologist ☐ Primary Care Provider ☐ Other

1) Number of *completed* appointments with participant over the last 3 months:

2) Number of participant's *missed* appointments in the last 3 months:

3) Medications prescribed including dosage and frequency, if applicable:

4) Is participant taking medications as prescribed? ☐ Yes ☐ No ☐ N/A
If no, please explain:

5) Dates and results of any drug tests, if applicable:

6) Have you observed changes in the individual's personal habits or general appearance? ☐ Yes ☐ No ☐ N/A
If yes, please explain:

7) Have you observed changes in the individual's interpersonal relationships? ☐ Yes ☐ No ☐ N/A
If yes, please explain:

8) Did the individual face any significant professional or personal challenges in the last 3 months? ☐ Yes ☐ No ☐ N/A
If yes, please explain:

9) Do you have any concerns about the individual's ability to practice safely? ☐ Yes ☐ No ☐ N/A
If yes, please explain:

Any additional comments:

Signature of Treatment Provider

Date

Would you like Pu'ulu Lapa'au to contact you? ☐ Yes ☐ No

Please return form by fax, email, mail, or upload to website

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