

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

Pu'ulu Lapa'au: Hawai'i Program for Healthcare Professionals
200 North Vineyard Boulevard, Building B, Suite 271
Honolulu, HI 96817
Phone: (808) 593-7444

FAX: (808) 593-8999

Email: maryann.lentz@hawaiiphp.org

Upload: hawaiiphp.org/forms