NEW MEXICO HEALTH PROFESSIONAL WELLNESS PROGRAM

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

Participant Name:_____ Reporting Period_____

Psychiatrist's
Name:_____Phone_____

As a psychiatric treatment provider for an HPWP participant your clinical assessment and treatment plan information is a necessary part of HPWP'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:

Medications

_____

_____

_____

_____

_____

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

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