



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