COMMITTEE FOR PHYSICIAN HEALTH
MEDICAL SOCIETY OF THE STATE OF NEW YORK
99 WASHINGTON AVENUE, SUITE 410, ALBANY, NEW YORK 12210
(518) 436-4723 – 800-338-1833 – Fax: (518) 436-7943
Downloadable forms at www.cphny.org (select "Forms")

QUARTERLY TREATMENT REPORT
(Therapy/Medication Management)

(Please Print Clearly)

Date: _____

Treatment Provider Name: _____ CPH Participant Name or Number:_____

☐ Individual ☐ Group ☐ Medication Management CPH Assistant Director: _____

REPORTING PERIOD: **(Please CHECK)**

____1st Quarter (January – March) – **Due March 31** ____3rd Quarter (July – September) – **Due September 30**

____2nd Quarter (April – June) – **Due June 30** ____4th Quarter (October – December) – **Due December 31**

CPH Treatment recommendations and/or requirements of compliance:

_____

_____

1. # Sessions Scheduled: _____ # Attended by Patient: _____ # Missed by Patient: _____

(Please explain missed sessions)_____

_____

2. Your treating diagnosis, treatment modalities/focus, anticipated changes in treatment.

_____

_____

3. Medication(s) prescribed/compliance/dosage/complications/changes. ( ) N/A

_____

_____

4. Participation in sessions: ( ) Active ( ) Neutral ( ) Reluctant ( ) Passive/Resistant ( ) Hostile/Challenge

5. Involvement in 12-step program: ( ) Meaningful, Ongoing ( ) Neutral, Compliant ( ) Superficial ( ) N/A

6. Has a sponsor? ( ) Yes ( ) No ( ) N/A Maintains regular contact with sponsor? ( ) Yes ( ) No

7. Overall progress rating:
   ( ) Actively working toward treatment goals
   ( ) Maintaining status quo since last report
   ( ) Regression or deterioration since last report (*explain*)

8. Would you like CPH to call you about this individual? ( ) Yes ( ) No

Comments/Concerns:

_____

_____

_____

_____

Signature **Date** **E-Mail Address**