



RE: _____ Date: _____

The Professionals Resource Network (PRN) has the above participant's consent to request reports from you on a periodic basis. This report is needed to ensure the participant's Contract compliance. We appreciate your taking the time to complete the information below as soon as possible. You may email the report to admin@flprn.org. You may also fax the report to 904-261-3996. If you have any questions regarding this reporting process, please do not hesitate to call this office (800-888-8776).

Diagnosis: DSM- _____

Is this diagnosis changed from last update? Yes No

Have you checked the E-Forcse/PDMP (Prescriber only)? Yes No

Current Medication (Prescriber only):

1. _____ 2. _____

3. _____ 4. _____

Level of Motivation for Treatment: _____
0 10

Compliance with Recommendations/Attendance (circle one):

High Moderate Low

Are you aware of any unapproved alcohol or drug use or unreported acting out behaviors?

No Yes _____

High Risk Issues:

For relapse/regression in addictive behaviors: _____

For relapse in other psychological/behavioral/medical areas: _____

Able to Practice with Reasonable Skill and Safety: Yes No

Plan:

Type of Intervention: _____

Frequency of Sessions: _____

Projected Length: _____

Please note: Any proposed change to the agreed upon plan on any party's part necessitates prior discussion with all parties (treatment provider/PRN participant/PRN).

Signature _____ Print Name _____

Would you like PRN to contact you? _____ Contact Number _____

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