HAVEN

Health Assistance InterVention Education Network

QUARTERLY MEDICATION MANAGEMENT REPORT

HAVEN ID #: _____

Reporting Period: ☐ **January to March – due April 15** ☐ **April to June – due July 15**
☐ **July to September – due Oct. 15** ☐ **October to December – due Jan. 15**

1. State the frequency of office visits.

_____

2. Has the frequency of visits been changed in the last quarter, and if so, is this change based on your recommendation? _____

3. Please list the current medications identified in your records/prescribed by you for this professional:

Medication Name	Daily Dose	Medication Name	Daily Dose

4. If any of the medications are controlled substances or mood altering medications, what other alternative treatment options been considered?

_____

When will the medication plan be reevaluated? (e.g. if chronic use, expect reevaluation at least every three months)_____

Is there a plan to discontinue or taper any medications, and if so, identify the medication?

_____

5. Has this health care professional been compliant with treatment?_____

6. Since the last report, have you referred this health care professional to any other health care professional for care and treatment, and if so state the name, address and reason for referral?

_____

7. From a treatment perspective, is this professional able to practice with reasonable skill and safety?
____Yes ____No

8. Would you like HAVEN to contact you about this participant? ☐ Yes ☐ No

If necessary, please attach an additional page to provide a confidential statement regarding this professional's ability to practice with reasonable skill and safety.

_____ _____
Printed Name and Title of Person completing report Signature

Date: _____

Address: _____ Telephone: _____

Preferred method of contact ☐Phone: ☐ Fax: ☐ Email: _____

FORM MAY BE FAXED TO HAVEN AT 860-828-3192 or emailed to: reports@haven-ct.org .