Lawyers and Judges Assistance Program
HEALTH PROFESSIONAL RECOVERY PROGRAM

Pain Provider Report Form

PARTICIPANT PROGRESS EVALUATION

Participant:_____

Report for the period from:_____ to _____

Please check the appropriate finding for each listed criteria	YES	NO
1. Has patient missed any appointments?		
If so, did they call and reschedule?		
2. Patient has used medication as prescribed?		
3. Patient has been compliant with treatment recommendations?		
4. I am satisfied, from the evidence available to me that my patient is not impaired and is safe to practice.		

5. Current medications prescribed in this office	Name	Strength	Dosing
6. Current diagnosis			

Please comment on any concerns:_____

_____

_____

_____

_____

_____

_____

Provider's Signature:_____ Date:_____

Provider's Name (type or print)_____

Provider's Address:_____

Provider's Telephone Number:_____