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Alexis Polles, M.D., Medical Director
Donna Young, Executive Director

RE:

PHN has the above participant's consent to request reports from you on a periodic basis. This report is needed to ensure participant's contract compliance. We appreciate your taking the time to complete the information below as soon as possible. A self-addressed envelope is enclosed for your convenience. You may also fax the report to the number listed above. If you have any questions regarding this reporting process, please do not hesitate to call this office.

<p>Diagnosis: Axis I- _____ Axis II - _____</p> <p>Current Medications (Prescriber only): 1) _____ 2) _____ 3) _____ 4) _____</p> <p>Level of Motivation for Treatment:</p> <p>_____ 0 _____ 10</p> <p>Compliance with Recommendations/Attendance (circle one):</p> <p>High Moderate Low</p> <p>Are you aware of any unapproved alcohol or drug use or unreported acting out behaviors.</p> <p>Yes No</p> <p>High Risk Issues:</p> <p>For relapse/regression in addictive behaviors:</p> <p>For relapse in other psychological/behavioral/medical areas:</p> <p>Plan:</p> <p>Type of Intervention _____ Frequency _____ Projected Length _____</p> <p>Other: _____</p> <p>Please note: Any proposed change to the agreed upon plan on any party's part necessitates prior discussion with all parties (treatment provider/PHN participant/PHN).</p>

Signature

Date

Would like PHN to contact you? _____ Contact number _____.