Healthcare Professionals' Foundation of Louisiana

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TREATING PSYCHIATRIST MEDICATION MANAGEMENT REPORT

(This form is to be completed on each visit.)

A. Patient (Participant): _____

B. Treating Professional: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

C. Reporting Period: _____
(Month or Date of Visit)

D. Please provide a treatment plan including the expected frequency of follow-up appointments for medication management.

_____

_____

_____

_____

_____

E. Please provide a brief comment regarding the effectiveness of the medication management and any difficulties. Please note if medication is no longer recommended.

_____

_____

_____

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_____

F. If applicable, please provide evidence of therapeutic level measurements.

_____

_____

_____ _____
Signature Date