PAS
PeerAssistanceServices

Peer Health Assistance Program
Provider Report

As a provider, PHAP relies upon you to provide current information regarding the licensee's ability to practice with reasonable skill and safety, based on his/her/their presentation during appointments or afterhours engagement with you/your facility. Please review the categories below for any concerns.

PAS Client:

Reporting Frequency: ☐ Monthly ☐ Quarterly

Reporting Period:

Frequency of visits:

Number of visits during this reporting period:

Has the licensee complied with visits and treatment as scheduled? ☐ Yes ☐ No

If no, why?

Current Physical/Behavioral Health Issues

ICD-10 Diagnosis	Current Treatment	Recommendation for Follow Up

Prescribed Medications	Dosage	Frequency

Has the licensee complied with his/her/their prescribed medication regimen? ☐ Yes ☐ No

Have you observed any of the following that may impair the licensee's ability to practice in his/her/their licensed profession with reasonable skill and safety?

Mood shifts/swings	☐ Yes ☐ No	Threats of harm to self	☐ Yes ☐ No
Tangentiality	☐ Yes ☐ No	Threat of harm to others	☐ Yes ☐ No
Changes in eating/sleeping patterns	☐ Yes ☐ No	Tactile, visual, and/or auditory hallucinations	☐ Yes ☐ No
Significant life event (loss, illness)	☐ Yes ☐ No	Impaired insight or judgement	☐ Yes ☐ No
Physical limitations	☐ Yes ☐ No		

If yes, please explain and **contact the PAS Case Manager IMMEDIATELY:**

Do you have any concerns about the licensee's ability to perform the following tasks in the workplace?

Think critically, plan, organize, and prioritize.	☐ Yes ☐ No	Develop/maintain a therapeutic provider-client relationship.	☐ Yes ☐ No
Remember and concentrate.	☐ Yes ☐ No	Respond appropriately to an emergency in the workplace.	☐ Yes ☐ No
Communicate effectively with staff.	☐ Yes ☐ No		

If yes, please explain and **contact the PAS Case Manager IMMEDIATELY:**

The above-named client does **not** have a physical and/or behavioral health issue that renders him/her/them unable to practice in the licensed profession with reasonable skill and safety. ☐ Agree ☐ Disagree

The above-named client does **not** exhibit compulsive patterns of behavior or those indicative of a return to use that may impair his/her/their ability to practice in the licensed profession with reasonable skill and safety.
☐ Agree ☐ Disagree

If disagree, please explain:

Additional comments/plans for changes to the treatment plan:

Thank you for your time completing this report. Your role as a medical or psychiatric provider is critical to the success of this licensee. Please do not hesitate to contact the Case Manager with any questions or concerns at 303-369-0039.

Signature:	Date:
Name:	Credentials:
Title:	Facility/Agency:
Email Address:	Phone: