Texas Physician Health Program
Mental Health Provider/Counselor Report Form

All records and information maintained by the TXPHP are confidential under Sec. 167.010 of the Medical Practice Act, and other state and federal statutes protecting patient and TXPHP participant privacy and are not subject to disclosure.

Re: _____ _____
Name of TXPHP participant TXPHP #

Date: _____

Mental health provider's name: _____

Address: _____

City, state, zip: _____

Phone #: _____ Email: _____

The following information is supplied with the above-named participant's consent:

I have been informed that this patient is being monitored by TXPHP for : ☐ Substance Use Disorder ☐ Psychiatric disorder ☐ Neurocognitive disorder ☐ Other, please specify: [text box]

Date of 1st visit: _____ Date of last visit: _____ Frequency of visits: _____

Diagnosis(es): _____

1. **Participant's adherence with my treatment and recommendations:**

   ☐ Completely adhering

   ☐ Partially adherent for the following reason(s): _____

   ☐ Resistant, but resistance issues are minor and are a continuing focus in therapy. Reasons for resistance _____

   ☐ Significantly resistant for the following reason(s): _____

2. **Mental health provider's plan for follow up and frequency of same:**

   ☐ Psychotherapy ☐ Other, please specify: [text box]

Frequency: _____Date of next visit: _____

3. **Statement concerning the presence of impairment due to disorder(s) for which I am seeing this patient:**

   Based on my current evaluation and clinical opinion:

   ☐ I DO ☐ I DO NOT

   believe that the participant suffers from impairment related to a health condition that currently renders them unable to practice with reasonable skill and safety.

   If applicable, please explain why you believe the participant is unable to practice with reasonable skill and safety:_____

4. **Any additional information you believe would assist TXPHP in monitoring or advocating for this participant:**

   _____

   _____

   Please indicate if you would like for the TXPHP Medical Director to call and speak with you about this participant: Yes ☐ No ☐

   Individual that the Medical Director should contact: _____

   Dates/times available: _____

   Phone: _____ Day of Week and Time: _____

   Email: _____

Select one of the following:

[ ] I swear and affirm that my relationship with the TXPHP participant is solely for the purposes of mental health services and is limited to a practitioner-patient relationship only. I am not in any way related to the participant, nor do we have a personal relationship of any kind, a professional healthcare-related relationship of any kind, a business or financial relationship of any kind, or any other relationship that may present an ethical or professionalism issue.

[ ] I have a relationship with the TXPHP participant beyond the practitioner-patient relationship.

Describe all other relationships with the TXPHP participant. [text box for description]

Electronic Signature: ____