MINNESOTA
HEALTH PROFESSIONALS
SERVICES PROGRAM

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mn.gov/boards/hpsp

TREATMENT PROVIDER REPORT FORM

HPSP Participant Name:

_____

DOB: _____

Please Check Quarter Date:

Jan 15th☐ April 15th☐ July 15th☐ Oct. 15th☐

Number of visits in last quarter: _____

Primary Treatment Focus:

_____

Secondary Treatment Focus:

_____

Symptoms (i.e.: current, changes, exacerbations, relapse?):

Treatment Plan/Recommendations/Interventions:

Client/Patient Insight:

Please note that treatment providers may complete this form or provide a copy of most recent clinic notes.

Medications:

To the best if your knowledge, is the client/patient working in their licensed profession? Yes ☐ No ☐

To the best of your knowledge, has the client/patient changed jobs in the last three months? Yes ☐ No ☐

Please list recommended practice restrictions (if any):

Agency Name:

_____

Provider Name:

_____

Provider Signature:

_____

Provider Phone Number:

_____

Date:

_____

Return to HPSP via email hlbhpsp@state.mn.us
You may also fax or mail to HPSP.

Thank you!