



## NEW MEXICO MONITORED TREATMENT PROGRAM

**PSYCHIATRIC PROVIDER CLINICAL ASSESSMENT AND TREATMENT PLAN REPORT:** To be submitted *by participant* to MTP after each psychiatric appointment.

Participant Name: \_\_\_\_\_ Reporting Period \_\_\_\_\_

Psychiatrist's Name: \_\_\_\_\_ Phone \_\_\_\_\_

As a psychiatric treatment provider for an MTP participant your clinical assessment and treatment plan information is a necessary part of MTP's ability to understand and monitor this individual. Please fill out the requested information as completely as possible.

**Short summary of the patient's significant problems/symptoms:**

**DSM IV Diagnostic Assessment**

Axis I \_\_\_\_\_

Axis II \_\_\_\_\_

Axis III \_\_\_\_\_

Axis IV \_\_\_\_\_

Axis V \_\_\_\_\_

**Medications**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What are the goals for psychiatric treatment?**

**What is the Treatment Plan?**

**What is the individual's prognosis?**

**Is participant benefiting from psychiatric treatment?**

- ( ) Yes  
( ) No (please explain)

**Is the individual compliant with treatment?**

- ( ) Yes  
( ) No (please explain)

**Additional comments:**

\_\_\_\_\_  
Psychiatric Provider Signature

\_\_\_\_\_  
Date