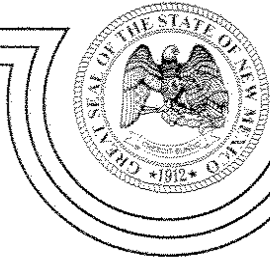
STATE OF NEW MEXICO

(505) 841-8345



Board Of Nursing
Diversion Program

6301 Indian School NE Suite 710
Albuquerque, New Mexico 87110

PRESCRIPTION AND CONTROLLED MEDICATION PROVIDER REPORT

TO BE SUBMITTED BY DP PARTICIPANT EVERY THREE (3) MONTHS

Nurse's Name____________________________________**License #**____________________________________

The individual listed above is a nurse being monitored by the New Mexico Board of Nursing Diversion Program. The New Mexico DP requires clinical information as part of the individual's assessment process and his/her rehabilitation and monitoring plan. This individual has informed us that you are prescribing prescription/controlled medications to him/her. Therefore, please respond to the following questions:

INSTRUCTIONS:

1. **Form must be filled out by *authorized prescribing practitioner/physician only*.**
2. **List all prescriptions/controlled medications, dosage & frequency.**
3. **Authorized prescriber to respond to all questions & submit additional comments if needed.**
4. **Authorized prescriber to sign and date form.**
5. **Provide address and contact information.**
6. **Contact Nancy Darbro, DP Coordinator w/questions (505) 841-8345 / Fax # (505) 841-9092**

Provider Name__________________________________**Facility Name**____________________________________

Address____**Month**____________**Year**_________

Phone number_________________________**Cell**__________________________**Fax**________________________

(1) What prescriptions/controlled medications are you currently prescribing for this individual? List Below.

	MEDICATION NAME	DOSAGE	FREQUENCY
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			

(2) What is the diagnosis that requires treatment with these medications?

(3) What other treatments have been attempted?

(4) What were the outcomes of these treatments?

(5) Is treatment with these medications the only effective treatment for the individual's condition? (If yes, please explain)

(6) How long do you anticipate that the individual will need to use this medication?

(7) Is there any evidence of prescription/controlled medication abuse? (If yes, please explain)

(8) Are current prescription medications interfering in any way with the individual's ability to practice in his/her profession and/or his/her overall functioning?

(9) Has the individual informed you that he/she has a substance abuse disorder or a past history of problems associated with the use of prescription/controlled medications?

(10) How have you discussed the long term consequences of the use of this prescription/controlled medication(s) with the individual?

Additional Comments:

I affirm the accuracy of all statements, responses and representations made above.

______________________________ ______ ______________________

Signature of Healthcare Provider **Month** **Day** **Year**

____

Phone # **Fax#**