

TAPNET PARTICIPANT SELF REPORT

DATE: _____
CASE #/MGR.: _____

INSTRUCTIONS: Complete this form and mail the original to TAPNET at the address below by the 10th of each month along with your TAPNET MONTHLY ATTENDANCE RECORD. **Please remember you are completing this form for the previous month.**

Name (Print): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Work: _____ Cell: _____

E-mail: _____

Check if this is a new address and/or phone numbers

ARE YOU CURRENTLY EMPLOYED? Counseling _____ Non-Counseling _____ Unemployed _____

PLACE OF EMPLOYMENT: _____

FOR ALL PARTICIPANTS

1. List all current prescription and over the counter medications:

Name of Medication	Prescribed by:	Date Prescribed:

2. Did your physician(s) send TAPNET the updated TAPNET Prescription Information form for the above?

Y ___ N ___ No chances ___ If not sent, will send on (date): _____

3. What requests do you have of TAPNET at this time? _____

4. How is participating in TAPNET benefiting you? _____

_____ If you are not benefiting, what would help? _____

5. What major changes have occurred in your life this month? _____

6. What are you doing to take care of yourself? _____

7. Who is your TAPNET Advocate? _____ Advocate's Phone #: _____

How many times have you seen your Advocate this month? _____

How many times have you spoken with your Advocate by phone this month? _____

FOR SUBSTANCE ABUSE/ DEPENDENCY

1. How many AA meetings per week are you attending? _____ What step are you working? _____
What does this step mean to you? _____

 2. Your 12 step sponsor's first name? _____ How often do you contact your sponsor? _____
When is the last time you met with your sponsor? _____
 3. Are you still attending aftercare? Y ___ N ___ if yes, has your treatment provider sent a progress report? Y ___ N ___
 4. Describe your current treatment plan: _____

 5. Name of your psychiatrist: _____ Dates seen this month: _____
 6. Name of your therapist: _____ Dates seen this month: _____
- Signature _____ Date _____
- Case # _____ Case Manager _____

FOR PSYCHIATRIC AND DUAL DIAGNOSIS

NOTE: WRITE N/A IF NOT APPLICABLE OR IF ALREADY ANSWERED IN PREVIOUS SECTION

1. Date discharged from inpatient, day hospital, or intensive outpatient program: _____
Name/Location of facility: _____
 2. Have you sent your prescription info/ Progress Report since your last appt? _____
 3. Describe your current treatment plan: _____

 4. Name of your psychiatrist: _____ Dates seen this month: _____
 5. Name of your therapist: _____ Dates seen this month: _____
- Signature _____ Date _____
- Case # _____ Case Manager _____

Please use the space below for any additional comments or information.