

Ohio Physicians Health Program

PARTICIPANT DEMOGRAPHIC & INTAKE INFORMATION

Full Name of Prospective Participant: (Please attach your CV)

Last _____ First _____ Middle _____

Degree: MD DO PAC DDS OTHER _____ Specialty _____

Date of Birth: _____ Spouse/Significant Other: _____

Home Address:

Street _____

City _____ State _____ Zip _____ County _____

Office Address:

Street _____

City _____ State _____ Zip _____ County _____

I prefer to receive OPHP correspondence at my _____ home address _____ office address

Phone: Home _____ Pager _____

Office _____ Cell _____

Email Address _____

Medical License number(s) and status of license(s): (Use reverse if additional space is needed.)

State _____ Number _____ Status _____

State _____ Number _____ Status _____

State _____ Number _____ Status _____

Primary Care Physician:

Name _____ Degree MD DO

Address where OPHP correspondence for PCP is to be mailed:

Street _____

City _____ State _____ Zip _____ County _____

Phone: _____ Email Address _____

Monitor: (please attach Monitor's CV)

Name _____ Degree MD DO DDS Other

Address where materials and correspondence for Monitor are to be mailed:

Street _____

City _____ State _____ Zip _____ County _____

Phone: _____ Email Address _____

Note: Please give your Monitor the Monitor Demographic Information Form to complete and return to OPHP in the attached business reply envelope.

Past and/or Present Medical Board, Court System, State or Hospital Monitoring Program involvement:
(Use reverse if additional space is needed.)

Name _____

Contact Person _____

Street _____

City _____ State _____ Zip _____

Phone _____

Name _____

Contact Person _____

Street _____

City _____ State _____ Zip _____

Phone _____

Medical Liability Insurance Information:

Name _____

Attorney (if applicable):

Name _____

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

MEDICATION RECORD

No.	Medication	Dosage	Purpose	Prescribing Physician
1				
2				
3				
4				
5				

(Use reverse if additional space is needed.)

Past or Present Treatment Program(s): (Use reverse if additional space is needed.)

Drug(s) of abuse (include all) _____

Sobriety Date _____

Name _____

Admission/Discharge Dates _____

Contact Person _____

Street _____

City _____ State _____ Zip _____

Phone _____

Name _____

Admission/Discharge Dates _____

Contact Person _____

Street _____

City _____ State _____ Zip _____

Phone _____

Past (in the last 10 years) and/or Present Therapist(s): (Use reverse if additional space is needed.)

Name _____ Degree/Credentials _____

Street _____

City _____ State _____ Zip _____ County _____

Phone: _____ Email Address _____

Treatment Date(s) _____

Purpose _____

Name _____ Degree/Credentials _____

Street _____

City _____ State _____ Zip _____ County _____

Phone: _____ Email Address _____

Treatment Date(s) _____

Purpose _____

Any additional person/organization that you think would be beneficial or necessary for OPHP to contact on your behalf: (Use reverse if additional space is needed.)

Name _____

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

Name _____

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

I am presently _____ Employed _____ Unemployed

I am _____ a resident _____ a solo practitioner _____ in a group practice _____ an employee

I found out about OPHP from _____

-or-

I was referred to OPHP by _____

Signature

Date

**** Please attach copies of any medical board, court, monitoring or treatment records, especially assessment and discharge summary/recommendations you may have in your possession. If these are unavailable to you, please contact the facility or agency and request that your records be forwarded to OPHP.****

Comments or questions: _____

Thank you,

Ohio Physicians Health Program (OPHP)