



**STEP 1 - CLINICAL TEAM REVIEW OF
HPRP CLINICAL TEAM DECISION**

TO BE COMPLETED BY LICENSEE

Licensee Name: _____ Case Number: _____

Case Manager: _____

• **Please review the Clinical Team’s decision regarding:**

- Inclusion** in HPRP as established by an evaluation
- Decisions subject to **individualization** in the written monitoring agreement:
 - Employment Controlled Substance Access Therapy Hours of Practice
 - Self-help/Caduceus Attendance Random Drug Screening Medication
 - Treating Physicians Other _____
- Closure** of case resulting in referral into the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing

• **Rationale for requesting a change in decision:**

I have attached additional documentation to support my request that was not available to the Clinical Team when their decision was made

Signature

Date



STEP 1 - CLINICAL TEAM REVIEW OF HPRP CLINICAL TEAM DECISION

TO BE COMPLETED BY TREATMENT PROVIDER OR EVALUATOR

Licensee Name: _____

Provider Name: _____

Relationship to licensee: Addictionist Psychiatrist Pain Specialist Therapist

Opinion of request:

- Support request
 Do not support request

Rationale – Please complete the following as they pertain to your opinion of the request:

Subjective: (What the client tells you, or what pertinent others tell you about the client; how the client experiences the world)

Objective (factual, what the providers observes/witnesses quantifiable; outside written materials received by provider)

Assessment (summarizes the counselor's clinical thinking; a synthesis and analysis of the subjective and objective portion of the notes)

Plan (describe the parameters of treatment; consists of an action plan and prognosis)

Additional Comments:

Signature

Date

P.O. Box 842 · Troy, Michigan 48099-0842 · (800) 453-3784 · Fax: (248) 519-0373