TREATMENT PROVIDER REPORT

Participant Name: ____________________________

Primary Treatment Focus: ____________________

Secondary Treatment Focus: __________________

<table>
<thead>
<tr>
<th>Medication</th>
<th>Indication</th>
<th>Dosage &amp; Frequency</th>
<th>Number of Refills</th>
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Please use the back of this form if you need additional space to list medications.

Participant’s current diagnosis: ____________________________

Has there been any change in Participant’s diagnosis? If yes, please explain: ____________________________

Participant’s treatment plan, recommendations, and interventions: ____________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Please submit this form to ASBN staff by the tenth (10th) of the following months:

☐ Jan ☐ Feb ☐ March ☐ April ☐ May ☐ June ☐ July ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec

Fax: (501) 686-2714 / Email: lwooten@arsbn.org

(Treatment Provider signature) (Print name and title)

(DATE) (Address and phone number)