FORM X

Ohio Board of Nursing *www.nursing.ohio.gov*
17 S. High Street, Suite 660 • Columbus, Ohio 43215-3466 • 614-466-3947

HEALTHCARE PROVIDER EVALUATION FORM

Please submit this form directly to the Ohio Board of Nursing's Alternative Program for Chemical Dependency/Substance Use Disorders by mail or by fax (#614-466-0710).

Participant Name: _____

Healthcare Practitioner: _____ Phone: _____

Date and Purpose of Visit: _____

Rule 4723-6-03(B), Ohio Administrative Code, requires all Participants to remain alcohol and drug free except for medications prescribed by a legally authorized prescriber and that the Participant inform all practitioners of their chemical dependency and recovery status **prior to receiving** any treatment and/or prescription(s).

The above named Participant has informed me of his/her chemical dependency history and recovery status prior to my provision of treatment and/or prescriptions? Yes _____ No _____

Diagnosis:

_____

_____

_____

Treatment:

_____

_____

_____

Recommendations:

_____

_____

_____

Please provide the following concerning all current medications (prescription, over-the-counter, vitamins, and herbal preparations):

Rx Medication/Dosage/Frequency	**# Prescribed/# Refills**	**Start Date**	**Stop Date**

List Participant's current over-the-counter medications, vitamins, and herbal preparations:

_____
_____
_____
_____

Discontinued Medications:

_____
_____

Work Activities: May/May not return to nursing/dialysis practice with/without restrictions

_____
_____
_____
_____

_____ _____
Practitioner's Signature Date