IPN MEDICATION MANAGEMENT EVALUATION

To the Practitioner of _____, a participant in the Intervention Project for Nurses (IPN)
(Participants name)

Please take a few moments to complete the form below. **The form must be completed by the prescribing Practitioner only. If you have any questions, please call IPN at (1-800) 840-2720.**

ANY MEDICATION OR DOSE CHANGES SINCE LAST EVALUATION?

Please List Current Prescription Information Below

Date of Rx	Name of Rx	Dosage	Qty. Prescribed	# of Refills	Diagnosis

PLEASE RATE BY PUTTING AN "X" BY THE APPROPRIATE NUMBER AND PROVIDE COMMENTS IN SPACE

	EXCELLENT	*GOOD*	*AVG.*	*BELOW*	*POOR*
1. **Cognitive functioning**	**5( )**	**4( )**	**3( )**	**2( )**	**1( )**
Comments: _____					
2. **Judgment**	**5( )**	**4( )**	**3( )**	**2( )**	**1( )**
Comments: _____					
3. **Problem-solving ability**	**5( )**	**4( )**	**3( )**	**2( )**	**1( )**
Comments: _____					
4. **Ability to cope with stressful situations**	**5( )**	**4( )**	**3( )**	**2( )**	**1( )**
Comments: _____					

5. **Do you feel this nurse is safe to practice:** **Yes ( )** **No ( )**

Reviewed with participant? **No( ) / Yes( ) If yes, participant signature**_____

Please call the IPN Office at (904) 270-1620 to discuss any concerns or receive clarification regarding this nurse's individual monitoring plan. Thank you.

Practitioner's Name (Please Print): _____
Practitioner's Signature: _____ Date: _____
Mailing Address: _____
City:_____ State:_____ Zip:_____ County:_____
Practitioner's email address:_____@_____
Phone: (___)_____ Fax: (____)_____

Please return this form by fax 904-270-1633 or mail to:
IPN, P.O. Box 49130, Jacksonville Beach, FL 32240-9130
O:\Forms\Medication Mgt Eval 07.09.18.docx