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( )**
2. **Judgment**	**5( )**	**4( )**	**3( )**	**2( )**	**1( )**
3. **Problem-solving ability**	**5( )**	**4( )**	**3( )**	**2( )**	**1( )**
4. **Ability to cope with stressful situations**	**5( )**	**4( )**	**3( )**	**2( )**	**1( )**

Comments: _____

_____

Comments: _____

_____

Comments: _____

_____

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
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