TENNESSEE LAWYERS ASSISTANCE PROGRAM
TLAP

Medication Management Report

To the practitioner: Please take a moment to complete the report below. After completing, fax/email the report to the TLAP office within five (5) days of any prescriptions. The completed report must be sent by the practitioner only. **Phone: 615-741-3238 Fax: 615-741-3508 Email: tlap@tncourts.gov**

Patient Information

Patient's Name: _____ Patient's DOB: _____

Patient has informed the prescriber of his/her history with TLAP: **Y** ◯ N ◯

Nature of Medical Condition (Include specific diagnosis) and Summary of Treatment:

_____

_____

_____

_____

Treatment Period From: _____ Treatment Period To: _____

Prescription Information

DATE OF MEDICATION	NAME OF MEDICATION	QUANTITY & DOSAGE # OF REFILLS	REASON FOR MEDICATION	CONTROLLED, MOOD ALTERING OR ADDICTIVE
				Y ◯ N ◯
				Y ◯ N ◯
				Y ◯ N ◯
				Y ◯ N ◯

Prescriber's information

By signature below, I verify that the information provided is correct. I understand that this individual submits to random drug screens and the use of narcotics or controlled substances, when alternative treatments are available, should be avoided.

_____ _____

Prescriber's Name (Please Print) *Prescriber's' Address*

_____ _____

Prescriber's Phone Number *Prescriber's Fax Number and Email Address*

_____ _____

Signature *Date*