

PRDP

Program for Recovering Dental Professionals
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Boise, ID 83706

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YEARLY UPDATED PRESCRIPTION DRUG LIST

This form is to be filled out by any practitioner who is prescribing you medications.
The Completed form must be mailed/faxed by the practitioner's office.

(Printed Participant's Name)

Prescription Date	Type of Medication	Quantity and Dosage Prescribed/Number of Refills	Reason for Medication

I have been informed that this patient is involved in a monitoring program. I understand that his/her drug(s) of choice is/are: _____

And/or

I have been informed that this patient is involved in a monitoring program. I understand that he/she has a mental health diagnosis of: _____

Practitioner's Name (Please print)

Practitioner's Signature

Practitioner's Phone Number

Date

Practitioner's Address