



Washington Health Professional Services
 PO Box 47864
 Olympia, WA 98504-7864
 Phone: 360-236-2880 Fax: 360-664-8588
 Email: whps@doh.wa.gov

Washington Health Professional Services Prescription Information Letter

Dear Healthcare Provider:

The nurse who is submitting this form is enrolled in Washington Health Professional Services (WHPS) which is the state run monitoring program for nurses with substance use disorders. In order to retain his/her license, the nurse has agreed to participate in WHPS to ensure abstinence and the ability to practice safely. All prescribed mind–mood altering and potentially addictive medications must be reported to WHPS, by the prescriber using the provided form, immediately and at least every 3 months.

WHPS identifies mind-mood altering or potentially addictive medications as:

- All medications on the U.S. [DEA schedule](#).
- Some medications not listed on the U.S. DEA schedule such as Atropine, Benadryl, Dextromethorphan and all alcohol containing preparations.
- Mental health medications such as antidepressants and antianxiety medications.

Nurses in the WHPS monitoring program possess a higher risk of relapse from both prescription and some over-the-counter medications. Therefore, WHPS also requires a health care provider’s recommendation for the use of mind-mood altering and potentially addictive over-the-counter medications such as antihistamines, antitussive/expectorants, and weight loss medications.

Alternatives to the use of mind-mood altering and potentially addictive medications should always be considered. A good resource for persons in recovery is the [Talbot Medication Guide](#)

WHPS cannot provide treatment recommendations; however, we may require the nurse to receive additional consultation from a mental health, addictions, and/or pain management specialist. Please contact WHPS at any time with questions, comments, or concerns regarding prescription medication procedures including requirements for third party consultation.

WHPS requests that you:

1. Review the nurse’s Prescription Monitoring Program (PMP) report before you prescribe any new or existing medications and fax/email a copy along with the Prescription Information Form. Directions for accessing the PMP database can be found at [Prescription Monitoring Program](#)
2. Adhere to the opioid prescribing practices contained in the [AMDG 2015 Interagency Guideline on Prescribing Opioids for Pain](#)

 Health Practitioner Signature

 Date

 Agency/Practice

 Telephone/Fax

Please sign and fax or email the Prescription Information Letter and the Prescription Information Form to WHPS. FAX 360-664-8588 email whps@doh.wa.gov



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Washington Health Professional Services Prescription Information Form

This form is to be completed by the healthcare provider for all prescribed mind-mood altering and potentially addictive medications every 3 months. Please sign and fax (360-664-8588) or email (whps@doh.wa.gov) the completed form to Washington Health Professional Services (WHPS).

Patient Name (print name) _____

Prescription Information Form						
Date	Name of Medication	Quantity	Dosage	Expiration Date	Refills	Diagnosis/Reason for Medication

Healthcare Provider's Report:

Appointment frequency: _____ Date of next appointment: _____

- Y ___ N ___ I have been informed this nurse is in recovery for substance abuse disorder?
- Y ___ N ___ Is the nurse compliant with keeping appointments?
- Y ___ N ___ Is the nurse compliant with taking medications?
- Y ___ N ___ Does the nurse demonstrate insight, awareness, and judgment necessary to manage medication(s)?
- Y ___ N ___ Is a copy of the nurse's Prescription Monitoring Program report attached?
- Y ___ N ___ Based on the above information and provider's clinical judgment, is the nurse safe to practice at this time?
 (If you answer "no" to any of the questions above, please explain below)

Treatment Progress Report: (if more space is needed, please attach another sheet)

Healthcare Provider Information: (Please print)

Name: _____ Credentials: _____
 Facility/Name of Practice: _____
 Address: _____ City: _____ State: _____ Zip code: _____
 Phone (enter 10 digit#): _____ Fax (enter 10 digit #): _____
 Healthcare Provider Signature: _____ Date: _____