

MIDWEST HEALTH MANAGEMENT SERVICES, LLC
SOUTH DAKOTA HEALTH PROFESSIONALS ASSISTANCE PROGRAM
3130 West 57th Street Suite 111 ♦ Sioux Falls SD 57108
Tel: (605) 275-4711 ♦ Fax: (605) 275-4715

To the Practitioner of the Health Professionals Assistance Program Participant:

Please take a few moments to complete this form, then fax or mail the completed form to the South Dakota HPAP office. The form must be completed by the practitioner only. If you have any questions, please contact the South Dakota HPAP office.

NAME OF PATIENT: _____
(Please Print)

PRESCRIPTION INFORMATION			
DATE OF PRESCRIPTION	MEDICATION	QUANTITY & DOSAGE <u>PRESCRIBED</u> NUMBER OF REFILLS	REASON FOR MEDICATION
1.			
2.			
3.			

I have been informed that this patient is participating in SD HPAP.

PRACTITIONER NAME (Please Print)

PRACTITIONER SIGNATURE

DATE

OFFICE TELEPHONE

ADDRESS