

IPRN, INC.
INITIAL TELEPHONE CONTACT FORM

Date: _____
Name & IPRN Position of Person Taking Call: _____

CALLER INFORMATION

1. Name _____
Address _____
Phone # (W) (____) _____ (H) (____) _____
E-Mail _____
2. Caller Description (if impaired professional go to #1 below):
- | | |
|--|---|
| a. Family Member <input type="checkbox"/> | e. Drake College of Pharmacy <input type="checkbox"/> |
| b. Colleague <input type="checkbox"/> | f. Board of Pharmacy <input type="checkbox"/> |
| c. Employer/Employee (circle one) <input type="checkbox"/> | g. Other <input type="checkbox"/> _____ |
| d. U of I College of Pharmacy <input type="checkbox"/> | |

IMPAIRED PROFESSIONAL INFORMATION

1. Name _____
Address _____
Phone # (W) (____) _____ (H) (____) _____
E-Mail _____
2. Impaired Professional Description:
- a. Impaired Pharmacist
1) Licensure: Yes No State(s): _____
- b. Impaired Pharmacy Technician
1) Registered: Yes No State(s): _____
- c. Impaired Pharmacy Student
1) Licensed Intern: Yes No State(s): _____
3. Gender: Male Female
4. Age Category: under 20 21-29 30-39
 40-49 50-59 60+

5. Employee Status at Intake: Full Time Part Time Retired
 Unemployed Leave of Absence
 Student Questionable
 Other: _____

6. Employment position or Student Status:
(e.g. owner, director, manager, staff, expected graduation date)

7. Presenting Problem: Alcohol
 Drugs
 Questionable Mental Health
 Questionable Physical Health
 Medical Diagnosis _____

8. Past/Present Status with the Board of Pharmacy:

9. Anticipated Need Category: Resource Only Intervention
 Treatment Referral Advocate Support
 Other: _____

10. Other Information: _____

11. Recommendation: _____

