

# PRDP

Program for Recovering Dental Professionals  
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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.**

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(Printed Participant's Name)

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

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