APPENDIX 6
FIELD EXPERIENCE MANUAL

NEW MEXICO STATE UNIVERSITY PSYCHOPHARMACOLOGY TRAINING

SUPERVISED CLINICAL EXPERIENCE TRAINING MANUAL

Rev. 12/2016

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FORM 400-7

400-hour Practicum Patient Intake Forms
FOR ADULTS
FOR ADOLESCENTS

(These are sample forms. You may use the following forms or another of your choosing as long as all necessary information is recorded.
Please see the New Mexico RxP regulations)

(Prescribing Psychologist Student Letterhead)

INTAKE FORM (Adolescent 12-17)

Please Use Ink

Name_____Sex: ❑ Male ❑ Female DOB_____
Age_____Social Security#_____
Address_____City_____ State_____ Zip Code_____
Home telephone_____
Emergency contact_____ Relationship_____Telephone_____
School_____ Grade_____ Teacher's Name_____Telephone_____

Information about Mother:

Name_____ DOB_____ Age____ SS#_____
Address:_____City_____ State_____ Zip Code_____
Home telephone_____ Work Phone_____ Cell Phone_____
Years of School Completed____ Place of Employment_____
Type of Work_____ E-mail address_____
Marital Status_____ Number of Marriages____ Religion_____

Information about Father:

Name_____ DOB_____ Age____ SS#_____
Address:_____City_____ State_____ Zip Code_____
Home telephone_____ Work Phone_____ Cell Phone_____
Years of School Completed____ Place of Employment_____
Type of Work_____ E-mail address_____
Marital Status_____ Number of Marriages____ Religion_____

OTHERS IN THE HOME:

Name	DOB	Age	Relationship

Ht:_____Wt:_____

(Note: Please check what applies to YOUR family history and please list any HX, then specify who on the line provided, such as paternal uncle, maternal grandmother, etc.

| | | |

APPENDIX 6
FIELD EXPERIENCE MANUAL

NEUROLOGICAL

Headaches	☐	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐	☐
Blackouts	☐	☐	☐	☐	☐
Head injury	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Convulsions/ seizures	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐

ADDICTIONS

Alcohol	☐	☐	☐	☐	☐
Drugs	☐	☐	☐	☐	☐
Nicotine	☐	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐

PULMONARY/LUNGS

Asthma	☐	☐	☐	☐	☐
Bronchitis	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐
Pneumonia	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐

DIGESTIVE (GI)

Stomach/duodenal ulcer	☐	☐	☐	☐	☐
Nausea or vomiting	☐	☐	☐	☐	☐
Weight loss and/or gain	☐	☐	☐	☐	☐
Diverticulosis	☐	☐	☐	☐	☐
Colitis	☐	☐	☐	☐	☐
Blood in stools	☐	☐	☐	☐	☐
Constipation or diarrhea	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐

REPRODUCTIVE

Hepatitis	☐	☐	☐	☐	☐
Genital herpes	☐	☐	☐	☐	☐
Liver problems	☐	☐	☐	☐	☐
Gallbladder problems	☐	☐	☐	☐	☐
Hernia	☐	☐	☐	☐	☐
Breast disease	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐

CARDIOVASCULAR

High or low blood pressure	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐
Arteriosclerosis	☐	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐	☐
Chest pain	☐	☐	☐	☐	☐
Irregular heartbeat	☐	☐	☐	☐	☐
Heart murmur	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐

EYE/EARS/NOSE/THROAT

Dental/oral problem	☐	☐	☐	☐	☐
Eye or eyelid infection	☐	☐	☐	☐	☐
Other eye problems	☐	☐	☐	☐	☐
Ear infection	☐	☐	☐	☐	☐
Deafness or decreased hearing	☐	☐	☐	☐	☐
Allergies or hay fever	☐	☐	☐	☐	☐
Frequent nosebleeds	☐	☐	☐	☐	☐
Difficulty swallowing	☐	☐	☐	☐	☐
Strep throat	☐	☐	☐	☐	☐

KIDNEY/RENAL

Kidney or bladder disease	☐	☐	☐	☐	☐

ENDOCRINE/METABOLIC

Thyroid problems	☐	☐	☐	☐	☐
Diabetes (Type I or Type II	☐	☐	☐	☐	☐

Present
Past
Uncertain
None
Family Hx
Who

	Present	Past	Uncertain	None	Family Hx	Who
Prostate problem (males)	☐	☐	☐	☐	☐	
Gynecologic problem (females)	☐	☐	☐	☐	☐	
Hemorrhoids	☐	☐	☐	☐	☐	

HEMATOLOGIC

Anemia	☐	☐	☐	☐	☐	
Bleeding	☐	☐	☐	☐	☐	
Other:_____	☐	☐	☐	☐	☐	

IMMUNE SYSTEM

Medication allergies	☐	☐	☐	☐	☐	
Food allergies	☐	☐	☐	☐	☐	
Other allergies, excluding ENT	☐	☐	☐	☐	☐	
Tumor(s), cancerous or benign	☐	☐	☐	☐	☐	
Other:_____	☐	☐	☐	☐	☐	

INFECTIONS

Measles	☐	☐	☐	☐	☐	
German measles/Rubella	☐	☐	☐	☐	☐	
Polio	☐	☐	☐	☐	☐	
Mumps	☐	☐	☐	☐	☐	
Scarlet fever	☐	☐	☐	☐	☐	
Chicken pox	☐	☐	☐	☐	☐	
Mononucleosis	☐	☐	☐	☐	☐	
Other:_____	☐	☐	☐	☐	☐	

DERMATOLOGIC/SKIN

Eczema	☐	☐	☐	☐	☐	
Psoriasis	☐	☐	☐	☐	☐	
Skin rash	☐	☐	☐	☐	☐	
Open wound(s)	☐	☐	☐	☐	☐	
Other:_____	☐	☐	☐	☐	☐	

MUSCULSKELETAL

Arthritis or other stiffness	☐	☐	☐	☐	☐	
Gout	☐	☐	☐	☐	☐	
Muscle weakness	☐	☐	☐	☐	☐	
Muscle pain	☐	☐	☐	☐	☐	
Bone fracture	☐	☐	☐	☐	☐	
Other:_____	☐	☐	☐	☐	☐	

CURRENT HEALTH HABITS	**Yes**	**No**
Daily aerobic exercise	☐	☐
Stable weight	☐	☐
Stable sleep	☐	☐
Coping skills for stress	☐	☐
Wake up rested most mornings	☐	☐
Have someone to turn to when troubled or upset	☐	☐

Please list all medications (include over-the-counter) and their doses that you are currently taking:

MEDICATION	DOSE	MEDICATION	DOSE

1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Have you ever been hospitalized for a psychiatric reason? ❑ Yes ❑ No
Please list all hospitalizations, medical and psychiatric:

Dates of hospitalization	Place	Reason	Psychiatric medications prescribed, if any

Your answers to this questionnaire can help me to quickly and accurately understand your concerns.

	Yes
1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks, or longer? (If YES, continue with next question; if NO, skip to Question 5.)	❑
2. Have you become less interested in things you used to enjoy most of the time?	
3. When something good happens, do you feel better, even if only temporarily?	❑
4. Have you felt sad, low, or depressed most of the time for the last two years?	❑
5. Other than when intoxicated on drugs or alcohol, have you ever felt so "up" or "high" that other people thought you were not your usual self?	❑
6. Have you ever gone for days at a time without feeling the need for much sleep?	❑
7. Are you currently feeling "up," "'high," or full of energy?	❑
8. Have you been frequently irritable, over-reacting to setbacks that you or others would consider relatively minor?	❑
9. Have you had anxiety attacks, i.e., become intensely frightened, uncomfortable, or uneasy, for no apparent reason?	❑
10. Do you feel anxious or uneasy in particular places or situations?	❑
11. In the past month, have you been repeatedly bothered by unwanted thoughts or images?	❑
12. In the past month, have you done something repeatedly without being able to resist doing it?	❑
13. Have you ever experienced or witnessed serious injury or threat to yourself or another person, or an actual death?	❑
14. Have your ever re-experienced a distressing event through dreams, flashbacks, or physical reactions?	❑
15. In the past 12 months, have you had three or more alcoholic drinks within a three hour period on more than three occasions?	❑
16. In the past 12 months, did you drink alcohol or take a drug, more than once, to get high, feel better, or change your mood?	❑
If so, which of the following did you use?	
Stimulants, amphetamines, Speed, crystal meth, Dexedrine, Ritalin, diet pills.	❑

Cocaine: snorting, IV, freebase, crack, "Speedball." ❑

Narcotics, heroin, morphine, methadone, painkillers. ❑

Hallucinogens: LSD ("acid"), mescaline, peyote, PCP ("Angel dust," "Peace Pill"), psilocybin, STP, mushrooms, Ecstasy, MDA, or MDMA. ❑

Inhalants: glue, ethyl chloride, nitrous oxide ("laughing gas"), amyl or butyl nitrate ("Poppers"). ❑

Marijuana: hashish, THC. ❑

Tranquilizers or downers. ❑

Miscellaneous: steroids, nonprescription sleep aides, diet pills, other_____ ❑

17. In the past three months, have you ever eaten a huge amount of food within a two-hour period? ❑

18. Would people who know you well describe you as a worrier? ❑

19. Have you ever felt that you should cut down on your drinking/drug use? ❑

20. Has anyone annoyed you by telling you to cut down on your drinking/drug use? ❑

21. Have you ever felt guilty or bad about your drinking/drug use? ❑

22. Do you ever wake up in the morning wanting to have an alcoholic drink or take drugs (eye opener)? ❑

23. Has anyone ever criticized you or told you that you have a gambling problem? ❑

24. Have you ever had to lie to family members, friends, or therapists about your gambling practices? ❑

25. In the past month, have you wanted to harm yourself? ❑

26. In the past month, did you have suicidal thoughts (e.g., wished you were dead or would be better off dead)? ❑

27. Have you ever made a suicide plan? ❑

28. Have you ever attempted suicide? ❑

FAMILY MENTAL HEALTH HISTORY

Family Member	Age, if still living	Mental health or substance abuse problems, if any*	If deceased, age at death	If deceased, cause of death
Mother				
Father				
Sister/Brother (circle one)				
Sister/Brother (circle one)				
Sister/Brother (circle one)				
Sister/Brother (circle one)				
Sister/Brother (circle one)				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

*Such as: alcoholism, drug addiction, depression, bipolar disorder, schizophrenia, ADHD, anxiety/panic, obsessive-compulsive disorder (OCD), learning disability, sleep disorder, violent tendencies.

NAME: _____ **Visit Type:** *Intake Follow-up Med Check Other* **Date:** _____

	Never	Rarely	Some-times	Frequently	Almost Always	SD	IR	SR
1. I get along with others.	4	3	2	1	0	✚		✚
2. I tire quickly.	0	1	2	3	4		✚	✚
3. I feel no interest in things.	0	1	2	3	4		✚	✚

4. I feel stressed at work/school/housework/volunteering.	0	1	2	3	4	+	+	
5. I blame myself for things.	0	1	2	3	4		+	+
6. I feel irritated.	0	1	2	3	4		+	+
7. I feel unhappy in my marriage/significant relationship.	0	1	2	3	4	+		+
8. I have thoughts of ending my life.	0	1	2	3	4		+	+
9. I feel weak.	0	1	2	3	4		+	+
10. I feel fearful.	0	1	2	3	4		+	+
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	0	1	2	3	4		+	+
12. I find my work/school/ housework/volunteering satisfying.	4	3	2	1	0	+	+	
13. I am a happy person.	4	3	2	1	0		+	+
14. I work/study too much.	0	1	2	3	4	+	+	
15. I feel worthless	0	1	2	3	4		+	+
16. I am concerned about family troubles.	0	1	2	3	4	+		+
17. I have an unfulfilling sex life.	0	1	2	3	4	+		+
18. I feel lonely.	0	1	2	3	4	+		+
19. I have frequent arguments.	0	1	2	3	4	+		+
20. I feel loved and wanted.	4	3	2	1	0	+		+
21. I enjoy my spare time.	4	3	2	1	0	+	+	
22. I have difficulty concentrating.	0	1	2	3	4		+	+
23. I feel hopeless about the future.	0	1	2	3	4		+	+
24. I like myself.	4	3	2	1	0		+	+
25. Disturbing thoughts come into my mind that I can't get rid of.	0	1	2	3	4		+	+
26. I feel annoyed by people who criticize my drinking (or frequent drug use). (If not applicable, mark "never")	0	1	2	3	4	+		+
27. I have an upset stomach.	0	1	2	3	4		+	+
28. I am not working/studying housework/volunteering as well as I used to.	0	1	2	3	4	+	+	
29. My heart pounds too much.	0	1	2	3	4		+	+
30. I have trouble getting along with my friends and close acquaintances.	0	1	2	3	4	+		+
31. I am satisfied with my life.	4	3	2	1	0		+	+
32. I have trouble at work/school housework/volunteering because of drinking or drug use. (If not applicable, mark "never")	0	1	2	3	4	+	+	
33. I feel that something bad is going to happen.	0	1	2	3	4		+	+
34. I have sore muscles.	0	1	2	3	4		+	+
35. I feel afraid of open spaces, or driving, or being on buses, subways, and so forth.	0	1	2	3	4		+	+
36. I feel nervous.	0	1	2	3	4		+	+
37. I feel my love relationships are full and complete.	4	3	2	1	0	+		+
38. I feel that I am not doing well at work/school.	0	1	2	3	4	+	+	
39. I have too many disagreements at work/school.	0	1	2	3	4	+	+	
40. I feel something is wrong with my mind.	0	1	2	3	4		+	+
41. I have trouble falling asleep or staying asleep.	0	1	2	3	4		+	+
42. I feel blue.	0	1	2	3	4		+	+
43. I am satisfied with my relationships with others.	4	3	2	1	0	+		+
44. I feel angry enough at work/school housework/volunteering to do something I may regret.	0	1	2	3	4	+	+	
45. I have headaches.	0	1	2	3	4		+	+
46. I feel restless & can't sit still.	0	1	2	3	4	+	+	+
47. I hear or see things that may not be there.	0	1	2	3	4	+	+	+
48. I do impulsive things (spending/gambling/dangerous driving)	0	1	2	3	4	+	+	+
49. My thoughts race.	0	1	2	3	4	+	+	+
					TOTAL:			

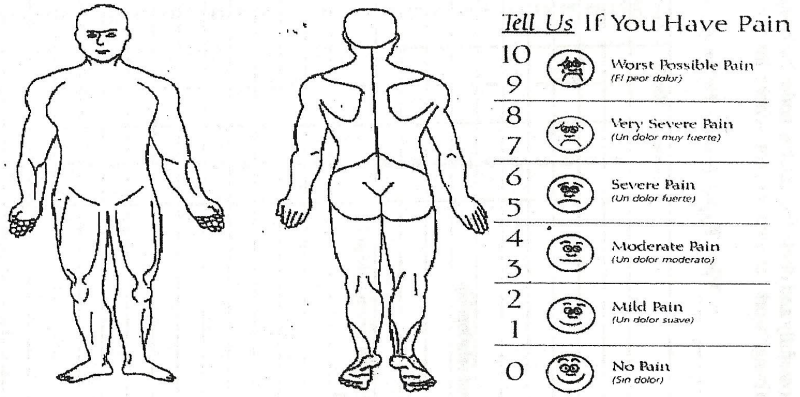
WELL-BEING QUESTIONNAIRE

Directions: Please circle any of the following that apply to you:

Blurred vision	Dry mouth	Excess saliva	Difficulty swallowing	Dizziness	Memory problems	Restless	Too happy
Oversensitive to criticism		Impulsive	Living dangerously (spending, gambling, speeding)		Racing thoughts		Seeing or hearing things that are not there
Constipation	Diarrhea	Hyper-feeling	Difficulty breathing	Weird thoughts	Violent thoughts		Trouble falling asleep
	Trouble staying asleep	Early morning awakening		Frequent troubling nightmares		Vivid dreaming	

PAIN SURVEY IF APPLICABLE

Directions: On the diagrams below, please mark the areas where you are experiencing pain:



Since the last session have you…

…lost or gained weight? ☐ Yes ☐ No. If Yes, explain: _____

…had any new medical problems? ☐ Yes ☐ No. If Yes, explain: _____

…noticed any new medication side-effects? ☐ Yes ☐ No. If Yes, explain: _____

…visited a health care provider? ☐ Yes ☐ No. If Yes, explain: _____

…started, stopped, or changed the dosage of any medication, herb, supplement, caffeine, or nicotine? ☐ Yes ☐ No. If Yes, explain: _____

…experienced stressful events at home, school, or work? ☐ Yes ☐ No. If Yes, explain: _____

Do you need a refill on any of your medications? ☐ Yes ☐ No. If Yes, please list with current dosage: _____

Even though we will ask to make a copy of your child's insurance card, we would appreciate if you would fill in the following information:

PRIMARY INSURANCE COMPANY

Name of Insurance Company_____ Policy#_____ Group#_____

Authorization or Referral Number_____

Name of Insured Person_____ DOB _____ SS#_____

Address, Phone Numbers and Place of Employment for Insured (if different from first page):

Address:_____City_____ State_____ Zip Code_____

Home telephone_____ Cell Phone_____

Place of Employment_____ Work Phone_____

SECONDARY INSURANCE COMPANY

Name of Insurance Company_____ Policy#_____ Group#_____

Authorization or Referral Number_____

Name of Insured Person_____ DOB _____ SS#_____

Address, Phone Numbers and Place of Employment for Insured (if different from first page):

Address:_____City_____ State_____ Zip Code_____

Home telephone_____ Cell Phone_____

Place of Employment_____ Work Phone_____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process insurance claims:

☐ Yes ☐ No

I authorize payment of medical benefits to (Prescribing Psychology Student Name) for services rendered:

☐ Yes ☐ No

SIGNED: _____DATE:_____

Name of person who referred you to this office_____

Why are you seeking treatment for your child now? _____

_____

_____

Has your child ever seen a therapist or counselor before? ❑ Yes ❑ No

If yes, what was the name of therapist?_____

Dates and reason for therapy_____

For each item, below, please check your preference and provide your initials; then sign below:

_____ ❑ Yes ❑ No I grant permission for (Prescribing Psychology Student Name) to speak with my child's physician about my child's psychological and medical status.

_____ ❑ Yes ❑ No I grant permission for (Prescribing Psychology Student Name) to speak about my child's psychological and/or medical status with *(other healthcare provider's name, address, and phone number):*_____

_____

_____ ❑ Yes ❑ No I grant permission for (Prescribing Psychology Student Name) to speak with my child's teacher and other school personnel at_____ *(name of school)*about how my child is doing in school.

_____ ❑ Yes ❑ No I grant permission for (Prescribing Psychology Student Name) to release medical or other information about my child's care to my child's insurance company, in order to process insurance claims.

_____ ❑ Yes ❑ No I authorize payment of medical benefits to (Prescribing Psychology Student Name) for services rendered.

All questions on your account should be directed to:

_____

I have read (Prescribing Psychology Student Name) ❑ Yes ❑ No practice and privacy policies, and consent to this patient-psychologist agreement on behalf of my child.

_____ **_____**

Parent or Guardian's Signature Date

INTAKE FORM (Adult)

PLEASE USE INK

Today's Date_____

Name_____ DOB_____ Age____ Social Security#_____

Address:_____City_____ State_____ Zip Code_____

Home telephone_____ Work Phone_____ Cell Phone_____

Years of School Completed____ Place of Employment_____

Type of Work_____ E-mail address_____

Marital Status_____ Number of Marriages____ Religion_____

Information about Spouse/Partner:

Name_____ DOB_____ Age____ Social Security#_____

Address:_____City_____ State_____ Zip Code_____

Home telephone_____ Work Phone_____ Cell Phone_____

Years of School Completed____ Place of Employment_____

Type of Work_____ E-mail address_____

Marital Status_____ Number of Marriages____ Religion_____

OTHERS IN THE HOME:

Name	**DOB**	**Age**	**Relationship**

Ht:_____ **Wt:**_____

(Note: Please check what applies to YOU. If you have a family member, please list HX, then specify who on the line provided, such as paternal uncle, maternal grandmother, etc.

	Present	Past	Uncertain	None	Family hx	Who
NEUROLOGICAL						
Headaches	☐	☐	☐	☐	☐	
Dizziness	☐	☐	☐	☐	☐	
Fatigue	☐	☐	☐	☐	☐	
Blackouts	☐	☐	☐	☐	☐	
Head injury	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	
Convulsions/ seizures	☐	☐	☐	☐	☐	
Other:_____	☐	☐	☐	☐	☐	
ADDICTIONS						
Alcohol	☐	☐	☐	☐	☐	
Drugs	☐	☐	☐	☐	☐	
Nicotine	☐	☐	☐	☐	☐	
Caffeine	☐	☐	☐	☐	☐	
Other:_____	☐	☐	☐	☐	☐	
PULMONARY/LUNGS						
Asthma	☐	☐	☐	☐	☐	
Bronchitis	☐	☐	☐	☐	☐	
Emphysema	☐	☐	☐	☐	☐	
Pneumonia	☐	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	☐	
Other:_____	☐	☐	☐	☐	☐	
DIGESTIVE (GI)						
Stomach/duodenal ulcer	☐	☐	☐	☐	☐	
Nausea or vomiting	☐	☐	☐	☐	☐	
Weight loss and/or gain	☐	☐	☐	☐	☐	
Diverticulosis	☐	☐	☐	☐	☐	
Colitis	☐	☐	☐	☐	☐	
Blood in stools	☐	☐	☐	☐	☐	
Constipation or diarrhea	☐	☐	☐	☐	☐	
Other:_____	☐	☐	☐	☐	☐	

	Present	Past	Uncertain	None	Family Hx	Who
REPRODUCTIVE						
Hepatitis	☐	☐	☐	☐	☐	
Genital herpes	☐	☐	☐	☐	☐	
Liver problems	☐	☐	☐	☐	☐	
Gallbladder problems	☐	☐	☐	☐	☐	
Hernia	☐	☐	☐	☐	☐	
Breast disease	☐	☐	☐	☐	☐	
Other:_____	☐	☐	☐	☐	☐	
CARDIOVASCULAR						
High or low blood pressure	☐	☐	☐	☐	☐	
High cholesterol	☐	☐	☐	☐	☐	
Arteriosclerosis	☐	☐	☐	☐	☐	
Heart attack	☐	☐	☐	☐	☐	
Chest pain	☐	☐	☐	☐	☐	
Irregular heartbeat	☐	☐	☐	☐	☐	
Heart murmur	☐	☐	☐	☐	☐	
Other:_____	☐	☐	☐	☐	☐	
EYE/EARS/NOSE/THROAT						
Dental/oral problem	☐	☐	☐	☐	☐	
Eye or eyelid infection	☐	☐	☐	☐	☐	
Other eye problems	☐	☐	☐	☐	☐	
Ear infection	☐	☐	☐	☐	☐	
Deafness or decreased hearing	☐	☐	☐	☐	☐	
Allergies or hay fever	☐	☐	☐	☐	☐	
Frequent nosebleeds	☐	☐	☐	☐	☐	
Difficulty swallowing	☐	☐	☐	☐	☐	
Strep throat	☐	☐	☐	☐	☐	
KIDNEY/RENAL						
Kidney or bladder disease	☐	☐	☐	☐	☐	
ENDOCRINE/METABOLIC						
Thyroid problems	☐	☐	☐	☐	☐	
Diabetes (Type I or Type II	☐	☐	☐	☐	☐	

	Present	Past	Uncertain	None	Family Hx	Who
Prostate problem (males)	☐	☐	☐	☐	☐	
Gynecologic problem (females)	☐	☐	☐	☐	☐	
Hemorrhoids	☐	☐	☐	☐	☐	
HEMATOLOGIC						
Anemia	☐	☐	☐	☐	☐	
Bleeding	☐	☐	☐	☐	☐	
Other:_____	☐	☐	☐	☐	☐	
IMMUNE SYSTEM						
Medication allergies	☐	☐	☐	☐	☐	
Food allergies	☐	☐	☐	☐	☐	
Other allergies, excluding ENT	☐	☐	☐	☐	☐	
Tumor(s), cancerous or benign	☐	☐	☐	☐	☐	
Other:_____	☐	☐	☐	☐	☐	
INFECTIONS						
Measles	☐	☐	☐	☐	☐	
German measles/Rubella	☐	☐	☐	☐	☐	
Polio	☐	☐	☐	☐	☐	
Mumps	☐	☐	☐	☐	☐	
Scarlet fever	☐	☐	☐	☐	☐	
Chicken pox	☐	☐	☐	☐	☐	
Mononucleosis	☐	☐	☐	☐	☐	
Other:_____	☐	☐	☐	☐	☐	
DERMATOLOGIC/SKIN						
Eczema	☐	☐	☐	☐	☐	
Psoriasis	☐	☐	☐	☐	☐	
Skin rash	☐	☐	☐	☐	☐	
Open wound(s)	☐	☐	☐	☐	☐	
Other:_____	☐	☐	☐	☐	☐	

	Present	Past	Uncertain	None	Family Hx	Who
MUSCULSKELETAL						
Arthritis or other stiffness	☐	☐	☐	☐	☐	
Gout	☐	☐	☐	☐	☐	
Muscle weakness	☐	☐	☐	☐	☐	
Muscle pain	☐	☐	☐	☐	☐	
Bone fracture	☐	☐	☐	☐	☐	
Other:_____	☐	☐	☐	☐	☐	

CURRENT HEALTH HABITS	**Yes**	**No**
Daily aerobic exercise	☐	☐
Stable weight	☐	☐
Stable sleep	☐	☐
Coping skills for stress	☐	☐
Wake up rested most mornings	☐	☐
Have someone to turn to when troubled or upset	☐	☐

Please list all medications (include over-the-counter) and their doses that you are currently taking:

MEDICATION	DOSE	MEDICATION	DOSE
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Have you ever been hospitalized for a psychiatric reason? ❑ Yes ❑ No
Please list all hospitalizations, medical and psychiatric:

Dates of hospitalization	Place	Reason	Psychiatric medications prescribed, if any

Your answers to this questionnaire can help me to quickly and accurately understand your concerns.

	Yes
1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks, or longer? (If YES, continue with next question; if NO, skip to Question 5.)	❑
2. Have you become less interested in things you used to enjoy most of the time?	
3. When something good happens, do you feel better, even if only temporarily?	❑
4. Have you felt sad, low, or depressed most of the time for the last two years?	❑
5. Other than when intoxicated on drugs or alcohol, have you ever felt so "up" or "high" that other people thought you were not your usual self?	❑
6. Have you ever gone for days at a time without feeling the need for much sleep?	❑
7. Are you currently feeling "up," "'high," or full of energy?	❑
8. Have you been frequently irritable, over-reacting to setbacks that you or others would consider relatively minor?	❑
9. Have you had anxiety attacks, i.e., become intensely frightened, uncomfortable, or uneasy, for no apparent reason?	❑
10. Do you feel anxious or uneasy in particular places or situations?	❑
11. In the past month, have you been repeatedly bothered by unwanted thoughts or images?	❑
12. In the past month, have you done something repeatedly without being able to resist doing it?	❑
13. Have you ever experienced or witnessed serious injury or threat to yourself or another person, or an actual death?	❑
14. Have your ever re-experienced a distressing event through dreams, flashbacks, or physical reactions?	❑

15. In the past 12 months, have you had three or more alcoholic drinks within a three hour period on more than three occasions? ❑

16. In the past 12 months, did you drink alcohol or take a drug, more than once, to get high, feel better, or change your mood? ❑

If so, which of the following did you use?

Stimulants, amphetamines, Speed, crystal meth, Dexedrine, Ritalin, diet pills. ❑

Cocaine: snorting, IV, freebase, crack, "Speedball." ❑

Narcotics, heroin, morphine, methadone, painkillers. ❑

Hallucinogens: LSD ("acid"), mescaline, peyote, PCP ("Angel dust," "Peace Pill"), psilocybin, STP, mushrooms, Ecstasy, MDA, or MDMA. ❑

Inhalants: glue, ethyl chloride, nitrous oxide ("laughing gas"), amyl or butyl nitrate ("Poppers"). ❑

Marijuana: hashish, THC. ❑

Tranquilizers or downers. ❑

Miscellaneous: steroids, nonprescription sleep aides, diet pills, other_____ ❑

17. In the past three months, have you ever eaten a huge amount of food within a two-hour period? ❑

18. Would people who know you well describe you as a worrier? ❑

19. Have you ever felt that you should cut down on your drinking/drug use? ❑

20. Has anyone annoyed you by telling you to cut down on your drinking/drug use? ❑

21. Have you ever felt guilty or bad about your drinking/drug use? ❑

22. Do you ever wake up in the morning wanting to have an alcoholic drink or take drugs (eye opener)? ❑

23. Has anyone ever criticized you or told you that you have a gambling problem? ❑

24. Have you ever had to lie to family members, friends, or therapists about your gambling practices? ❑

❑ 25. In the past month, have you wanted to harm yourself? ❑

26. In the past month, did you have suicidal thoughts (e.g., wished you were dead or would be better off dead)? ❑

❑ 27. Have you ever made a suicide plan? ❑

28. Have you ever attempted suicide? ❑

FAMILY MENTAL HEALTH HISTORY*Such as: alcoholism, drug addiction, depression, bipolar disorder, schizophrenia, ADHD, anxiety/panic, obsessive-compulsive disorder (OCD), learning disability, sleep disorder, violent tendencies

Family Member	Age, if still living	Mental health or substance abuse problems, if any*	If deceased, age at death	If deceased, cause of death
Mother				
Father				
Sister/Brother (circle one)				
Sister/Brother (circle one)				
Sister/Brother (circle one)				
Sister/Brother (circle one)				
Sister/Brother (circle one)				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

NAME: _____ **Visit Type:** *Intake Follow-up Med Check Other* **Date:** _____

	Never	Rarely	Some-times	Frequently	Almost Always	SD	IR	SR
1. I get along with others.	4	3	2	1	0	+		+
2. I tire quickly.	0	1	2	3	4		+	+
3. I feel no interest in things.	0	1	2	3	4		+	+
4. I feel stressed at work/school/housework/volunteering.	0	1	2	3	4	+	+	
5. I blame myself for things.	0	1	2	3	4		+	+
6. I feel irritated.	0	1	2	3	4		+	+
7. I feel unhappy in my marriage/significant relationship.	0	1	2	3	4	+		+
8. I have thoughts of ending my life.	0	1	2	3	4		+	+
9. I feel weak.	0	1	2	3	4		+	+
10. I feel fearful.	0	1	2	3	4		+	+
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	0	1	2	3	4		+	+
12. I find my work/school/ housework/volunteering satisfying.	4	3	2	1	0	+	+	
13. I am a happy person.	4	3	2	1	0		+	+
14. I work/study too much.	0	1	2	3	4	+	+	
15. I feel worthless	0	1	2	3	4		+	+
16. I am concerned about family troubles.	0	1	2	3	4	+		+
17. I have an unfulfilling sex life.	0	1	2	3	4	+		+
18. I feel lonely.	0	1	2	3	4	+		+
19. I have frequent arguments.	0	1	2	3	4	+		+
20. I feel loved and wanted.	4	3	2	1	0	+		+
21. I enjoy my spare time.	4	3	2	1	0	+	+	
22. I have difficulty concentrating.	0	1	2	3	4		+	+
23. I feel hopeless about the future.	0	1	2	3	4		+	+
24. I like myself.	4	3	2	1	0		+	+
25. Disturbing thoughts come into my mind that I can't get rid of.	0	1	2	3	4		+	+
26. I feel annoyed by people who criticize my drinking (or frequent drug use). (If not applicable, mark "never")	0	1	2	3	4	+		+
27. I have an upset stomach.	0	1	2	3	4		+	+
28. I am not working/studying housework/volunteering as well as I used to.	0	1	2	3	4	+	+	
29. My heart pounds too much.	0	1	2	3	4		+	+
30. I have trouble getting along with my friends and close acquaintances.	0	1	2	3	4	+		+
31. I am satisfied with my life.	4	3	2	1	0		+	+
32. I have trouble at work/school housework/volunteering because of drinking or drug use. (If not applicable, mark "never")	0	1	2	3	4	+	+	
33. I feel that something bad is going to happen.	0	1	2	3	4		+	+
34. I have sore muscles.	0	1	2	3	4		+	+
35. I feel afraid of open spaces, or driving, or being on buses, subways etc	0	1	2	3	4		+	+
36. I feel nervous.	0	1	2	3	4		+	+
37. I feel my love relationships are full and complete.	4	3	2	1	0	+		+
38. I feel that I am not doing well at work/school.	0	1	2	3	4	+	+	
39. I have too many disagreements at work/school.	0	1	2	3	4	+	+	
40. I feel something is wrong with my mind.	0	1	2	3	4		+	+
41. I have trouble falling asleep or staying asleep.	0	1	2	3	4		+	+
42. I feel blue.	0	1	2	3	4		+	+
43. I am satisfied with my relationships with others.	4	3	2	1	0	+		+
44. I feel angry enough at work/school housework/volunteering to do something I may regret.	0	1	2	3	4	+	+	
45. I have headaches.	0	1	2	3	4		+	+
46. I feel restless & can't sit still.	0	1	2	3	4	+	+	+
47. I hear or see things that may not be there.	0	1	2	3	4	+	+	+
48. I do impulsive things (spending/gambling/dangerous driving)	0	1	2	3	4	+	+	+
49. My thoughts race.	0	1	2	3	4	+	+	+
					TOTAL:			

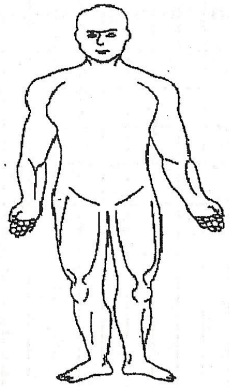
WELL-BEING QUESTIONNAIRE

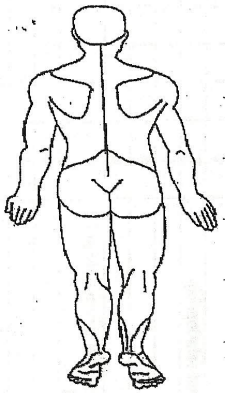
Directions: Please circle any of the following that apply to you:

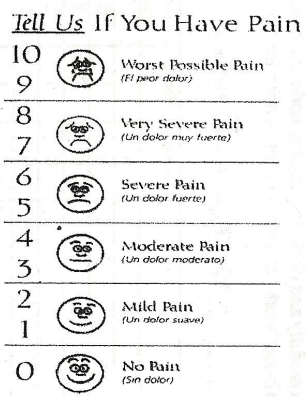
Blurred vision	Dry mouth	Excess saliva	Difficulty swallowing	Dizziness	Memory problems	Restless	Too happy
Oversensitive to criticism		Impulsive	Living dangerously (spending, gambling, speeding)		Racing thoughts	Seeing or hearing things that are not there	
Constipation	Diarrhea	Hyper-feeling	Difficulty breathing	Weird thoughts	Violent thoughts	Trouble falling asleep	
	Trouble staying asleep	Early morning awakening		Frequent troubling nightmares	Vivid dreaming		

PAIN SURVEY IF APPLICABLE

Directions: On the diagrams below, please mark the areas where you are experiencing pain:







Since the last session have you…

…lost or gained weight? ☐ Yes ☐ No. If Yes, explain: _____

…had any new medical problems? ☐ Yes ☐ No. If Yes, explain: _____

…noticed any new medication side-effects? ☐ Yes ☐ No. If Yes, explain: _____

…visited a health care provider? ☐ Yes ☐ No. If Yes, explain: _____

…started, stopped, or changed the dosage of any medication, herb, supplement, caffeine, or nicotine? ☐ Yes ☐ No. If Yes, explain: _____

…experienced stressful events at home, school, or work? ☐ Yes ☐ No. If Yes, explain: _____

Do you need a refill on any of your medications? ☐ Yes ☐ No. If Yes, please list with current dosage: _____

Even though we will ask to make a copy of your child's insurance card, we would appreciate if you would fill in the following information:

PRIMARY INSURANCE COMPANY

Name of Insurance Company_____ Policy#_____ Group#_____

Authorization or Referral Number_____

Name of Insured Person_____ DOB _____ SS#_____

Address, Phone Numbers and Place of Employment for Insured (if different from first page):

Address:_____City_____ State_____ Zip Code_____

Home telephone_____ Cell Phone_____

Place of Employment_____ Work Phone_____

SECONDARY INSURANCE COMPANY

Name of Insurance Company_____ Policy#_____ Group#_____

Authorization or Referral Number_____

Name of Insured Person_____ DOB _____ SS#_____

Address, Phone Numbers and Place of Employment for Insured (if different from first page):

Address:_____City_____ State_____ Zip Code_____

Home telephone_____ Cell Phone_____

Place of Employment_____ Work Phone_____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process insurance claims:

☐ Yes ☐ No

I authorize payment of medical benefits to (Prescribing Psychology Student Name) for services rendered:

☐ Yes ☐ No

SIGNED: _____DATE:_____

Name of person who referred you to this office_____

Why are you seeking treatment now? _____

_____

_____

Have you ever seen a therapist or counselor before? ❑ Yes ❑ No

If yes, what was the name of therapist?_____

Dates and reason for therapy_____

_____

For each item, below, please check your preference and provide your initials; then sign below:

_____ ❑ Yes ❑ No I grant permission for (Prescribing Psychology Student Name) to speak with my physician about my psychological and medical status.

_____ ❑ Yes ❑ No I grant permission for (Prescribing Psychology Student Name) to release medical or other information about my care to my insurance company, in order to process insurance claims.

_____ ❑ Yes ❑ No I authorize payment of medical benefits to (Prescribing Psychology Student Name) for services rendered.

All questions on your account should be directed to:

_____

I have read (Prescribing Psychology Student Name) ❑ Yes ❑ No practice and privacy policies, and consent to this patient-psychologist agreement on behalf of myself.

_____ _____

Patient's Signature Date

FORM 400-8

400-hour Practicum Initial Patient Intake Form
To Be Completed by Child Patients
(with parental assistance)

(May use the following form or another of your choosing as long as all necessary information is recorded.
Please see the New Mexico RxP regulations)

INTAKE FORM
(Child)

Today's Date_____

Information about Child:

Name_____ Sex: ❑ Male ❑ Female DOB_____
Age_____Social Security#_____
Address_____City_____ State_____ Zip Code_____
Height _____Weight _____
Home telephone_____
Emergency contact_____ Relationship_____Telephone_____
School_____ Grade_____ Teacher's Name_____Telephone_____

Information about Mother:

Name_____ DOB_____ Age____ SS#_____
Address:_____City_____ State_____ Zip Code_____
Home telephone_____ Work Phone_____ Cell Phone_____
Years of School Completed____ Place of Employment_____
Type of Work_____ E-mail address_____
Marital Status_____ Number of Marriages_____ Religion_____

Information about Father:

Name_____ DOB_____ Age____ SS#_____
Address:_____City_____ State_____ Zip Code_____
Home telephone_____ Work Phone_____ Cell Phone_____
Years of School Completed____ Place of Employment_____
Type of Work_____ E-mail address_____
Marital Status_____ Number of Marriages_____ Religion_____

OTHERS IN THE HOME:

Name	**DOB**	**Age**	**Relationship**

Your child's physician (name, phone, address):_____

Does your child have any allergies to medications? ❑ Yes ❑ No
If so, to which ones?:_____

To Foods? ❑ Yes ❑ No If so, to which ones?:_____

Has your child ever had any of the following medical problems? Circle yes or no

	Y	N		Y	N
Surgery	▯	▯	Chemical sensitivities	▯	▯
Heart disease	▯	▯	Frequent infections	▯	▯
Kidney disease	▯	▯	Frequent nausea and vomiting	▯	▯
Liver disease	▯	▯	Frequent constipation or diarrhea	▯	▯
Diabetes	▯	▯	Vision problems	▯	▯
Thyroid problem	▯	▯	Hearing problems	▯	▯
Endocrine disorder	▯	▯	Unexplained, severe pains	▯	▯
Seizures or other	▯	▯	Other unusual sensations	▯	▯
neurological disorder			Muscle weakness or fatigue	▯	▯
Substance abuse	▯	▯	Other medical illness	▯	▯
Headaches	▯	▯	Tumor(s), cancerous or benign	▯	▯
Dizziness	▯	▯	Measles	▯	▯
Asthma	▯	▯	German Measles/Rubella	▯	▯
Bronchitis	▯	▯	Polio	▯	▯
Tuberculosis	▯	▯	Mumps	▯	▯
Colitis	▯	▯	Scarlet Fever	▯	▯
Chest pain	▯	▯	Chicken Pox	▯	▯
Frequent nosebleeds	▯	▯	Mononucleosis	▯	▯
Strep throat	▯	▯	Muscle pain	▯	▯
Kidney/bladder disease	▯	▯	Bone fracture	▯	▯
Diabetes (Type I or Type II)	▯	▯	Eczema	▯	▯
Venereal Disease	▯	▯	Skin rash	▯	▯
Anemia	▯	▯			
Bleeding	▯	▯			

Has your child ever been referred to a psychiatrist or other prescriber for an evaluation for psychiatric medication? ❑ Yes ❑ No

Please list all medications and their doses (medical, psychiatric, non-prescription, herbal) that your child is currently taking:

Medication	Dose	Medication	Dose
1.		4.	
2.		5.	
3.		6.	

Has your child ever been hospitalized for a psychiatric reason? ❑ Yes ❑ No
Please list all hospitalizations, medical and psychiatric:

Dates of hospitalization	Place	Reason	Psychiatric medications prescribed, if any

Has your child ever had any of the following problems?

	Huge Problem	Moderate Problem	Minor Problem	No Problem	Past Problem	Family HX
Sleep problems: i.e., resists going to bed, interferes with parents' sleep, has trouble getting up in the morning						
Nightmares, night terrors, or sleep walking						
Finicky eating						
Eating too much						
Eating too little						
Dramatic changes in energy						
Up or Down?						
Frequent crying spells						
Anxiety, panic, nervousness						
Worry, intense shyness						
Depressed, sad, or hopeless						
Voiced thoughts of harming self						
Engaged in self-injury						
Attempted suicide						
Concerns about personal appearance						
Does purposeless things over and over						
Cannot get certain thoughts out of his/her head						
Unusual behavior or beliefs that seem strange to others						

	Huge Problem	Moderate Problem	Minor Problem	No Problem	Past Problem	Family HX
Easily irritated or frustrated						
Argues or becomes aggressive						
Has voiced thoughts of harming someone else						
Physically assaulted someone						
Risky behavior _____						
Behavior problems at school						
Academic problems						
Smokes cigarettes						
Acts without thinking						
Cannot stay focused						
Restless, fidgety, or hyper						
Breaks family or school rules						
Lies or steals						
Involvement in correctional system						
Alcohol problems						
Drug problems						
Past/present drug or alcohol problems?						
Other: _____						

Your answers to this questionnaire can help me to quickly and accurately understand your concerns. If adolescent, please complete. If parent, complete with child.

	Yes	No
1.) Has your child been consistently depressed or down, most of the day, nearly every day, for the past 2 weeks or longer? (If **YES**, continue with the next question; if **NO**, skip to Question 5	☐	☐
2.) Has your child become less interested in things you used to enjoy most of the time?	☐	☐
3.) When something good happens, does your child feel better, even if only temporarily?	☐	☐
4.) Has your child felt sad, low, or depressed most of the time for the last 2 years?	☐	☐
5.) Other than when intoxicated on drugs or alcohol, has your child ever felt so "up" or "high" that other people thought you were not your usual self?	☐	☐
6.) Has your child ever gone for days at a time without feeling the need for much sleep?	☐	☐
7.) Is your child currently feeling "up" "high", or "full of energy"?	☐	☐
8.) Has your child been frequently irritable, over-reacting to setbacks that you or others would consider relatively minor?	☐	☐
9.) Has your child had anxiety attacks, i.e. become intensely frightened, uncomfortable, or uneasy, for no apparent reason?	☐	☐
10.) Does your child feel anxious or uneasy in particular places or situations?	☐	☐
11.) In the past month, have you been repeatedly bothered by unwanted thoughts or images?	☐	☐
12.) In the past month, has your child done something repeatedly without being able to resist doing it?	☐	☐
13.) Has your child ever experienced or witnessed serious injury or threat to yourself or another person, or an actual death?	☐	☐
14.) Has your child ever re-experienced a distressing event through dreams, flashbacks, or physical reactions?	☐	☐
15.) In the past 12 months, have you had 3 or more alcoholic drinks within a 3 hour period on more than 3 occasions?	☐	☐
16.) In the past 12 months, did your child drink alcohol or take a drug, more than once, to get high, feel better, or change your mood?	☐	☐
If so, which of the following did your child use? (below)		
Hallucinogens: LSD ("acid"), mescaline, peyote, PCP ("Angel Dust", "Peace Pill"), Psilocybin, STP, Mushrooms, Ecstasy, MDA, or MDMA.	☐	☐
Inhalants: Glue, Ethyl Chloride, Nitrous Oxide ("laughing gas"), Amyl or Butyl Nitrate ("Poppers").	☐	☐
Cocaine: snorting, freebase, crack, IV, or "Speedball". Narcotics, Heroin, Morphine, Methadone, Painkillers.	☐	☐
Marijuana: Hashish, THC	☐	☐
Tranquilizers or Downers. Miscellaneous: Steroids, Non-prescription Sleep Aides, Diet Pills, Other: _____	☐	☐

	Yes	No
17.) In the past 3 months, has your child ever eaten a huge amount of food within a 2-hr period?	☐	☐
18.) Would people who know your child well describe him/her as a worrier?	☐	☐
19.) Has your child ever felt that he/she should cut down on drinking or drug use?	☐	☐
20.) Has anyone annoyed your child by telling him/her to cut down on drinking or drug use?	☐	☐
21.) Has your child ever felt guilty or bad about drinking or drug use?	☐	☐
22.) Does your child ever wake up in the morning wanting to have an alcoholic drink or take drugs (eye opener)?	☐	☐
23.) Has anyone ever criticized your child or told him/her that he/she has a gambling problem?	☐	☐
24.) Has your child ever had to lie to family members, friends, or therapists about his/her gambling practices?	☐	☐
25.) In the past month, has your child wanted to harm himself/herself?	☐	☐
26.) In the past month, did your child have suicidal thoughts (i.e., wished he/she were dead or would be better off dead?)	☐	☐
27.) Has your child ever made a suicide plan?	☐	☐
28.) Has your child ever attempted suicide?	☐	☐

FAMILY MENTAL HEALTH HISTORY

Family Member	Age, if still living	Mental health or substance abuse problems, if any*	If deceased, age at death	If deceased, cause of death
Mother				
Father				
Sister/Brother (circle one)				
Sister/Brother (circle one)				
Sister/Brother (circle one)				
Sister/Brother (circle one)				
Sister/Brother (circle one)				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

*Such as: alcoholism, drug addiction, depression, bipolar disorder, schizophrenia, ADHD, anxiety/panic, obsessive-compulsive disorder (OCD), learning disability, sleep disorder, violent tendencies.

Even though we will ask to make a copy of your child's insurance card, we would appreciate if you would fill in the following information:

PRIMARY INSURANCE COMPANY

Name of Insurance Company_____ Policy#_____ Group#_____

Authorization or Referral Number_____

Name of Insured Person_____ DOB _____ SS#_____

Address, Phone Numbers and Place of Employment for Insured (if different from first page):

Address:_____City_____ State_____ Zip Code_____

Home telephone_____ Cell Phone_____

Place of Employment_____ Work Phone_____

SECONDARY INSURANCE COMPANY

Name of Insurance Company_____ Policy#_____ Group#_____

Authorization or Referral Number_____

Name of Insured Person_____ DOB _____ SS#_____

Address, Phone Numbers and Place of Employment for Insured (if different from first page):

Address:_____City_____ State_____ Zip Code_____

Home telephone_____ Cell Phone_____

Place of Employment_____ Work Phone_____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process insurance claims:

☐ Yes ☐ No

I authorize payment of medical benefits to _____ for services rendered:

☐ Yes ☐ No

SIGNED: _____DATE:_____

Name of person who referred you to this office_____

Why are you seeking treatment for your child now? _____

_____

_____

Has your child ever seen a therapist or counselor before? ❑ Yes ❑ No

If yes, what was the name of therapist?_____

Dates and reason for therapy_____

_____

For each item, below, please check your preference and provide your initials; then sign below:

_____ ❑ Yes ❑ No I grant permission for (Prescribing Psychology Student Name) to speak with my child's physician about my child's psychological and medical status.

_____ ❑ Yes ❑ No I grant permission for (Prescribing Psychology Student Name) to speak about my child's psychological and/or medical status with *(other healthcare provider's name, address, and phone number)*:_____

_____

_____ ❑ Yes ❑ No I grant permission for (Prescribing Psychology Student Name) to speak with my child's teacher and other school personnel at_____ *(name of school)* about how my child is doing in school.

_____ ❑ Yes ❑ No I grant permission for (Prescribing Psychology Student Name) to release medical or other information about my child's care to my child's insurance company, in order to process insurance claims.

_____ ❑ Yes ❑ No I authorize payment of medical benefits to (Prescribing Psychology Student Name) for services rendered.

I have read _____'s practice and privacy policies, and the HIPPA information, and consent to this patient-psychologist agreement.

_____ _____ _____

Parent/Guardian Name (printed) **Parent/Guardian Signature** **Date**

FORM 400-9

400-hour Sample
Practicum Initial Patient Chart Form
To Be Completed by the Psychologist

Student Letterhead or Your Institution's Letterhead

400-Hour PRACTICUM FOR PRESCRIBING PSYCHOLOGISTS

INITIAL PATIENT DATA

Supervisee: _____

Patient Name:_____ **Patient Date of Birth:** _____

Date: _____ **Gender:** _____

Weight:_____ **Height:** _____

Ethnic Cultural Background:_____ **Medical History Form Completed** **Yes** ___ **No**___

Presenting Symptoms and History of Symptoms:

_____

_____

Review of Systems:

CONST:	Fever	Chills	Fatigue	Dizziness
ENT:	Sore Throat	Nasal Drainage	Nasal Congestion	
PULMONARY:	Cough Asthma Allergies	Sputum Bronchitis Other:	Trouble Breathing Emphysema	Chest Pain Pneumonia
CVS:	High Cholesterol High Blood Pressure Heart Attack	Heart Disease Irregular Heartbeat Heart Blockage	Atherosclerosis Foot Swelling	Stroke Anemia
MUS/SKEL:	Arthritis Back Pain	Muscle Pain Other:	Leg Pain	Fracture
OSTEO:	Arthritis	Other:		
GI:	Abdominal Pain Constipation Hernia	Nausea Black/Bloody Stools Hepatitis Ulcer	Vomiting Liver Problems Kidney Disease	Diarrhea Hemorrhoids Bladder Disease
GU:	Problems Urinating	Frequent Urination	Hemorrhoids	
SKIN:	Skin Rash	Eczema	Psoriasis	Open Wounds
NEURO/EYES:	Headaches Double Vision Eye Infections	Difficulty Walking Stroke Other:	Blackouts Head Injury	Difficulty w/Speech Seizures/Convulsions
ENDOCRINE:	Postmenopausal Diabetes Hypothyroid	Hysterectomy Prostate	Abnormal Discharge	Abnormal Bleeding Venereal

Hospitalizations and Surgeries:

Use of Alcohol, Drugs, Caffeine and Tobacco:

Significant Family History Including Medical and Mental Conditions:

Mental Status:

APPEARANCE:	Appropriate	Unclean	Disheveled	Other:	
BEHAVIOR:	Appropriate	Poor Eye Contact	Restless	Lethargic	Odd
ORIENTATION:	Time Asthma Allergies	Person Bronchitis Other:	Place Emphysema	Situation Pneumonia	Unable to Determine
SPEECH/LANGUAGE:	Organized Soft Sparse	Disorganized Loud Verbose	Rate NL Tone NL Nonverbal	Slow Monotone	Pressured Quantity NL
MOOD/AFFECT:	Euthymic	Depressed	Irritable	Tearful	
THOUGHT PROCESS:	Hypervigilant Inattentive	Linear Circumstantial	Tangential Coherent	Loose Trouble Concentrating	Racing
THOUGHT CONTENT:	Obsessional Worries	Grandiosity Self-Criticism	Hallucinations	Delusions	Paranoia
SUICIDE:	Ideation	Plan	IS w/o Means	Prior SA	
Discuss/Thought/Plan:					
HOMICIDE:	Ideation	Plan	HI w/o Means	HI w/Means	
Discuss/Thought/Plan:					

Vegetative Symptoms:

S - SLEEP:	Nightmares Insomnia	Flashbacks Hypersomnia	Hypnopompic Hallucinations	Hrs of Sleep ___ Hyperarousal	Hypnogogic Hallucinations
A - APPETITE CHANGE:	None	Decrease	Increase	Severe	Weight Change Loss ___ Gain ___
M - MEMORY:	Intact	Poor			
C - CONCENTRATION:	High	Decrease	Low	Intact	Slight Impairment
E - ENERGY:	High	Moderate	Low		
L - LIBIDO:	Increase	Decrease	Same	Other:	

Diagnosis:

AXIS I:	**AXIS V:**
AXIS II:	**GAF Score: ___**
AXIS III:	**Initial:_____ Current:** ___ **Highest in Last Yr _____**

AXIS IV – Psychosocial and Environmental Problems *(check all that apply)*

___None ___Legal System Interaction ___Primary Support Group ___Economic ____Occupational
___Housing ___Educational ___Social Environmental ___Access to Healthcare ____ Other

Comments:
_____

Patient's motivation for treatment: ___low ____ moderate ___high

Patient's strength:

Patient's obstacles to recovery:

Food allergies:

Drug allergies:

Conditions for which psychotropic drugs are contraindicated:

Primary symptoms to be targeted by the psychotropic medication:

	Mild	Moderate	Severe
Depressed Mood	1.___	2.___	3.___
Decreased Energy	1.___	2.___	3.___
Grief	1.___	2.___	3.___
Hopelessness	1.___	2.___	3.___
Worthlessness	1.___	2.___	3.___
Guilt	1.___	2.___	3.___
Anxiety	1.___	2.___	3.___
Panic Attacks	1.___	2.___	3.___
Obsessions/Compulsions	1.___	2.___	3.___
Elevated Mood	1.___	2.___	3.___
Irritability	1.___	2.___	3.___
Hyperactivity	1.___	2.___	3.___
Disruption of Thought-Process/Content	1.___	2.___	3.___
Delusions	1.___	2.___	3.___
Hallucinations	1.___	2.___	3.___
Paranoia	1.___	2.___	3.___
Dissociative State	1.___	2.___	3.___
Oppositionalism	1.___	2.___	3.___
Somatic Complaints	1.___	2.___	3.___
Impulsiveness	1.___	2.___	3.___
PTSD Symptomology	1.___	2.___	3.___
Sexual Trauma Perpetrator Symptomology	1.___	2.___	3.___
Substance Use	1.___	2.___	3.___
Other			
a._____	1.___	2.___	3.___
b._____	1.___	2.___	3.___

Relevant Findings from lab tests:
Discussion with PCP:
Discharge Criteria:

For Medical Conditions (prescription and over-the-counter):

Name of Medicine	Dosage	Prescribed By	Taken For	Date Started	Date Discontinued

Psychotropic Medications:

Name of Medicine	Dosage	Prescribed By	Taken For	Date Started	Date Discontinued

PSYCHOTHERAPY PLAN:

Data –

Assessment –

Plan –

Or

Subjective –

Objective –

Assessment –

Plan -

FORM 400-10

FORM 400-11

400-hour Practicum Symptom Outcome Questionnaire
To Be Completed by Adult Patients and Adolescent Patients at Initial Appointment and Before Each Follow-up Appointment
(Directions on how to score this outcome questionnaire follow)

Note: you do not need to use this outcome questionnaire but you are strongly encouraged to have your patients complete an objective measure at each session.

NAME: _____ **Visit Type:** *Intake Follow-up Med Check Other* **Date:** _____

	Never	Rarely	Some-times	Frequently	Almost Always	SD	IR	SR
1. I get along with others.	4	3	2	1	0	+		+
2. I tire quickly.	0	1	2	3	4		+	+
3. I feel no interest in things.	0	1	2	3	4		+	+
4. I feel stressed at work/school/housework/volunteering.	0	1	2	3	4	+	+	
5. I blame myself for things.	0	1	2	3	4		+	+
6. I feel irritated.	0	1	2	3	4		+	+
7. I feel unhappy in my marriage/significant relationship.	0	1	2	3	4	+		+
8. I have thoughts of ending my life.	0	1	2	3	4		+	+
9. I feel weak.	0	1	2	3	4		+	+
10. I feel fearful.	0	1	2	3	4		+	+
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	0	1	2	3	4		+	+
12. I find my work/school/ housework/volunteering satisfying.	4	3	2	1	0	+	+	
13. I am a happy person.	4	3	2	1	0		+	+
14. I work/study too much.	0	1	2	3	4	+	+	
15. I feel worthless	0	1	2	3	4		+	+
16. I am concerned about family troubles.	0	1	2	3	4	+		+
17. I have an unfulfilling sex life.	0	1	2	3	4	+		+
18. I feel lonely.	0	1	2	3	4	+		+
19. I have frequent arguments.	0	1	2	3	4	+		+
20. I feel loved and wanted.	4	3	2	1	0	+		+
21. I enjoy my spare time.	4	3	2	1	0	+	+	
22. I have difficulty concentrating.	0	1	2	3	4		+	+
23. I feel hopeless about the future.	0	1	2	3	4		+	+
24. I like myself.	4	3	2	1	0		+	+
25. Disturbing thoughts come into my mind that I can't get rid of.	0	1	2	3	4		+	+
26. I feel annoyed by people who criticize my drinking (or frequent drug use). (If not applicable, mark "never")	0	1	2	3	4	+		+
27. I have an upset stomach.	0	1	2	3	4		+	+
28. I am not working/studying housework/volunteering as well as I used to.	0	1	2	3	4	+	+	
29. My heart pounds too much.	0	1	2	3	4		+	+
30. I have trouble getting along with my friends and close acquaintances.	0	1	2	3	4	+		+
31. I am satisfied with my life.	4	3	2	1	0		+	+
32. I have trouble at work/school housework/volunteering because of drinking or drug use. (If not applicable, mark "never")	0	1	2	3	4	+	+	
33. I feel that something bad is going to happen.	0	1	2	3	4		+	+
34. I have sore muscles.	0	1	2	3	4		+	+
35. I feel afraid of open spaces, or driving, or being on buses, subways	0	1	2	3	4		+	+
36. I feel nervous.	0	1	2	3	4		+	+
37. I feel my love relationships are full and complete.	4	3	2	1	0	+		+
38. I feel that I am not doing well at work/school.	0	1	2	3	4	+	+	
39. I have too many disagreements at work/school.	0	1	2	3	4	+	+	
40. I feel something is wrong with my mind.	0	1	2	3	4		+	+
41. I have trouble falling asleep or staying asleep.	0	1	2	3	4		+	+
42. I feel blue.	0	1	2	3	4		+	+
43. I am satisfied with my relationships with others.	4	3	2	1	0	+		+
44. I feel angry enough at work/school housework/volunteering to do something I may regret.	0	1	2	3	4	+	+	
45. I have headaches.	0	1	2	3	4		+	+
46. I feel restless & can't sit still.	0	1	2	3	4	+	+	+
47. I hear or see things that may not be there.	0	1	2	3	4	+	+	+
48. I do impulsive things (spending/gambling/dangerous driving)	0	1	2	3	4	+	+	+
49. My thoughts race.	0	1	2	3	4	+	+	+
					TOTAL:			

WELL-BEING QUESTIONNAIRE

Directions: Please circle any of the following that apply to you:

Blurred vision **Dry mouth** **Excess saliva** **Difficulty swallowing** **Dizziness** **Memory problems** **Restless** **Too happy**

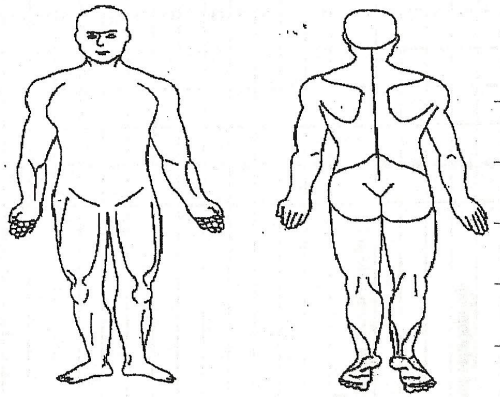
Oversensitive to criticism **Impulsive** **Living dangerously (spending, gambling, speeding)** **Racing thoughts** **Seeing or hearing things that are not there**

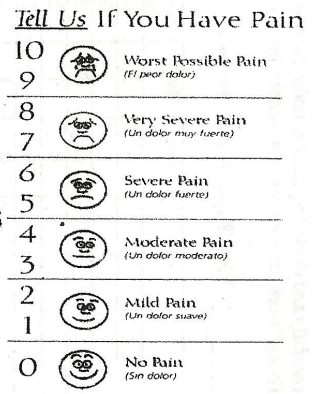
Constipation **Diarrhea** **Hyper-feeling** **Difficulty breathing** **Weird thoughts** **Violent thoughts** **Trouble falling asleep**

Trouble staying asleep **Early morning awakening** **Frequent troubling nightmares** **Vivid dreaming**

PAIN SURVEY IF APPLICABLE

Directions: On the diagrams below, please mark the areas where you are experiencing pain:





Since the last session have you…

…lost or gained weight? ☐ Yes ☐ No. If Yes, explain: _____

…had any new medical problems? ☐ Yes ☐ No. If Yes, explain: _____

…noticed any new medication side-effects? ☐ Yes ☐ No. If Yes, explain: _____

…visited a health care provider? ☐ Yes ☐ No. If Yes, explain: _____

…started, stopped, or changed the dosage of any medication, herb, supplement, caffeine, or nicotine? ☐ Yes ☐ No. If Yes, explain: _____

…experienced stressful events at home, school, or work? ☐ Yes ☐ No. If Yes, explain: _____

Do you need a refill on any of your medications? ☐ Yes ☐ No. If Yes, please list with current dosage: _____

Directions for Scoring the Outcome Questionnaire

This description of the Outcome Questionnaire 45 is written by John Drozd. Ph.D.,who completed the Master's Degree in Psychopharmacology Training at NMSU.

Purpose: Global outcome measure that assesses patient progress in therapy (not a diagnostic instrument). Assesses patient progress along 3 dimensions:

1) subjective discomfort or symptom distress (SD subscale, heavily loaded for depression and anxiety),
2) interpersonal relationship (IR subscale)
3) social role performance (SR subscale)

Overall Description: The OQ45.2 is a brief 45 item self-report outcome/tracking instrument designed for repeated measurement of client progress throughout the course of therapy and at termination. The OQ45.2 is the result of a unique partnership between behavioral health care administrators, practitioners, and academic researchers in response to the changing mental health arena and the accompanying demands for cost containment, quality care, reliable monitoring, and accountability for services provided. As continuous monitoring of outcome may be achieved by standardized data, Dr. Burlingame, Lambert, and Reisinger et al, set out to design an instrument that would meet the needs of both providers and payers.

Normative Sample: Normative data from community mental health and private freestanding outpatient clinics, EAP participants, and asymptomatic community and undergraduate populations are available. These normative samples (N=1,000+) were collected from sites in seven different states and reflect both gender (female = 60%) and age (from 17-80 years of age) diversity. Current analyses do not reflect any reliable normative differences by gender and age.

Psychometric Properties: The OQ45.2 is a standardized instrument with empirical support. It is based on normative data. Validity and reliability exceed industry standards.

Scoring and Interpretation: Total score is sum of 3 subscale scores (i.e. all 45 items) and yields a total score range from 0 – 180. The higher the score the more disturbed the individual.

Risk Assessment:

- Item 8 is a suicide potential screening item
- Items 11, 26, and 32 are substance abuse screening items
- Item 44 screens for violence at work.

Any rating on above Items other than 0 should be investigated further

Cutoff Score: When a patient scores a total score of 63 or higher, it is more likely that they are part of the clinical rather than the non-clinical ("normal") standardization sample.
Cutoff scores for subscales are:

Symptom Distress – 36,
Interpersonal Relations – 15,
Social Role – 12

Reliable Change Index: Total score changes of 14 points or more in either direction suggest reliable change (i.e., not due merely to measurement error)

FOR FURTHER INFORMATION

Burlingame, et. al. (1995). "Pragmatics of Tracking Mental Health Outcomes in a Managed Care Setting." Journal of Mental Health Administration, Summer, pp. 226-236.

Meredith, J.M., Lambert, M.J., & Drozd, J. F. (2001). Clinical outcomes assessment for the practicing clinician . In M.T. Sammons (Ed) Principles of Psychopharmacology, Washington, SC: APA Press.

Wells, et al. (1996) "Conceptualization and Measurement of Patient Change During Psychotherapy: Development of the Outcome Questionnaire and Youth Outcome Questionnaire". Psychotherapy, Sept-Oct, 1996.

FORM 400-11

400-hour Practicum Symptom Checklist To Be Completed by Child Patient (with parent's assistance if needed) Before Each Follow-up Session

Note: you do not need to use this outcome questionnaire but you are strongly encouraged to have your patients complete an objective measure at each session.

CHILD FOLLOW-UP CHECKLIST

Name: _____ **Date:**_____

Please rate the degree to which you experienced each of the following since the last session:

	Huge Problem	Moderate Problem	Minor Problem	No Problem	Past Problem	Family HX
Sleep problems: i.e., resists going to bed, interferes with parents' sleep, has trouble getting up in the morning						
Nightmares, night terrors, or sleep walking						
Finicky eating						
Eating too much						
Eating too little						
Dramatic changes in energy						
Up or Down?						
Frequent crying spells						
Anxiety, panic, nervousness						
Worry, intense shyness						
Depressed, sad, or hopeless						
Voiced thoughts of harming himself/herself						
Engaged in self-injury						
Attempted suicide						
Concerns about personal appearance						
Does purposeless things over and over						
Cannot get certain thoughts out of his/her head						
Unusual behavior or beliefs that seem strange to others						

	Huge Problem	Moderate Problem	Minor Problem	No Problem	Past Problem	Family HX
Easily irritated or frustrated						
Argues or becomes aggressive						
Has voiced thoughts of harming someone else						
Physically assaulted someone						
Risky behavior _____						
Behavior problems at school						
Academic problems						
Smokes cigarettes						
Acts without thinking						
Cannot stay focused						
Restless, fidgety, or hyper						
Breaks family or school rules						
Lies or steals						
Involvement in correctional system						
Alcohol problems						
Drug problems						
Past/present drug or alcohol problems?						
Other: _____						

Since the last session has your child…

…had any new medical problems? □ Yes □ No. If Yes, explain:_____

_____

These SIDE EFFECTS are sometimes experienced by a patient on medication. Has your child experienced any of these since being on MEDICATION?

Symptom	Severe Problem	Moderate Problem	Minor Problem	Medication	Approximate Start Date
Difficulty Falling asleep					
Difficulty waking up					
Interrupted sleep					
Extreme tiredness					
Trouble concentrating					
Loss of memory					
Headaches					
Shaking/ Tics/twitches					
Odd muscle movements					
Blurred vision					
Stomach distress					
Diarrhea					
Difficulty urinating					
Dry mouth					
Difficulty swallowing					
Inability to sit still					
Racing mind					

…visited a health care provider? □ Yes □ No. If Yes, explain:_____

…started, stopped, or changed the dosage of any medication, herb, supplement, caffeine, or nicotine? □ Yes □ No. If Yes, explain:_____

_____

…experienced stressful events at home, school, or work? □ Yes □ No

If Yes, explain:_____

_____

Does your child need a refill on any of his/her medications? □ Yes □ No. If Yes, please list with current dosage:

_____

Everything You Need to Know Now That Your Coursework is Complete

EVERYTHING YOU NEED TO KNOW
NOW THAT YOUR RXP COURSEWORK IS COMPLETE

Regarding the 80-hour Practicum

- You must complete an 80-hour practicum with a licensed physician.
- This Supervisor must sign an evaluation form. The evaluation form is on the www.nmsu.edu/academic-programs/clinical-psychopharmacology website in the handbook.
- You can have more than one supervisor; there has to be a primary supervisor who is an MD (not a nurse) who signs off on the form.
- Send a copy of the evaluation form to the Training Director. Keep the original of that evaluation form for yourself; you will have to submit it to the board to get your license.
- Must be completed in time frame from two weeks to thirty weeks.

You also need to complete a 100 patient/400 hour practicum in which you evaluate and treat patients for psychotropic intervention.

- You need to submit a practicum plan with your signature and the supervisor's signature to NMSU. I will sign it and return the original to you, and keep a copy in your student file.
- You must have one hour of supervision for each eight hours of clinical experience. If you are doing joint work with your supervisor, that qualifies as supervision time, as well as does the time talking about cases in between patient sessions.
- Writing case notes does not count. It has to be direct clinical time.
- You can have more than one Supervisor. The primary supervisor is responsible for getting feedback from the secondary supervisor at the midpoint and end of your program.
- You need to have an evaluation form completed after the first 50 patients and at end when you have seen 100 patients for 400 hours. That evaluation form is also in the practicum manual on the NMSU website.
- Send copies of those evaluation forms to the Training Director. Keep the original of it for yourself; you will need to send it to the Board in order to get your license.
- According to the law, there are records of the Practicum that you must keep:
    - A list of the dates and times you are with your supervisor.
    - A list of patients (using a code for their names to protect their identity) which describes the basic facts of each case.
    - Forms to use for those lists can be found on the website.

You must also keep a copy of your case notes.

- You do not need to send those case notes to the Training Director to get your degree, but, you must send a copy of your case notes to the Training Director before applying for your conditional license.

- The law requires that your Training Director look at your case notes.

- Must be completed in time frame of six months to three years

To remain eligible and apply for the Master's degree:

- You must register for two sections of the practicum with CEP 811 and 812 the semester after completing the coursework. If you are not finished with your practicum at that time, these will carry forward as an "I" until you are done.

- The semester you plan to graduate, you need to register for one credit of CEP 698.

- The semester you intend to graduate, please notify the Training Director as early as possible.

- When you register for the final semester:

  - Make sure that your program of study that has been filed

  - You must complete a form online stating your intention to graduate
    Go to your MYNMSU and find the link for application to graduate
    Follow the instructions for the interdisciplinary Masters (IMAS)

- There is a "Capstone Experience" that needs to be completed for any Master's degree. The Capstone Experience is to be taken the semester you plan to graduate. The Capstone is a short essay exam for you to complete which asks you to evaluate one of the cases of your practicum. The test has been written in a way that will, hopefully, give you the opportunity to think through some interesting matters.

- When you are ready to take the exam, contact the Training Director. It will be emailed to you. However, it is important that you ask for the exam at the beginning of the semester you plan to graduate, which will give you time to do it. The Capstone must be completed about six weeks before the semester ends.

Taking the PEP

- You are eligible to take the PEP as soon as you complete the coursework, even before you complete the Practicum.

- To get the official PEP application you need to email Jan Ciuccio (jciuccio@apa.org) at the American Psychological Association.

- You need to submit an official transcript from NMSU and a certificate of coursework completion with the application. You can obtain an official copy of your transcript from your MYNMSU link on your account.

- The pass rate for the exam is set somewhere around 71-72% of the items. It is hard to know exactly what the rate is until you have taken the test.

Applying for you conditional license to prescribe

- The information for applying for your conditional license is on the Board of Psychologist Examiners webpage. That information, as well as the forms for the application, can be downloaded from there.

- You will be asked to fill out an application form and send to the Board copies of your evaluation of each practicum. They may also ask for the documentation of the number of hours of supervision and basic data about your patients. You will also need to provide evidence that you passed the PEP.

- They will ask me to fill out a form about you. In order for me to do that, I must have the following:

    - Copies of your evaluation forms.

    - Copies of your case notes of your 100-hour practicum without the names (using a code to protect their identity) **OR** completion of the form titled Verification of Specifics of 100 Patients/400 hour Practicum (that form is attached.)

    - Two short forms which indicate your hours of supervision and basic data about the patients.

Moving from a conditional to an unconditional license to prescribe:

- During the two years of a conditional license, you must see 50 patients and you must be supervised for four hours a month.

- There is no formal interaction with the NMSU program necessary at this point. NMSU does not keep records of your work as a conditional prescribing psychologist.

- You can obtain the application forms on the Board of Psychologist Examiners website.

- After you apply, you will be contacted by the Board about how they will review your cases.

Getting an ABMP designation

- The American Board of Medical Psychology offers a Diplomate that allows you to put the initials ABMP after your name.
- You can then call yourself a "medical psychologist."
- They had an earlier grandfathering period which is now over. You now must complete an exam as well as document experience.
- Their requirements are online (www.abmp.org)

Remember, it is your responsibility that you progress smoothly through these steps.

- Please read New Mexico State University regulations regarding graduate school and a Master's degree.
- Please be familiar with the law for prescriptive authority.
- Please carefully read the regulations for prescriptive authority.
- I have tried to make these notes as inclusive as possible, but there are so many steps and so many specific items, it really is important for you to become familiar with the regulations for yourself.

Final Form to be Submitted to the Training Director

Form 400-12

POST-DOCTORAL MASTER'S OF ARTS DEGREE
NEW MEXICO STATE UNIVERSITY

Verification of Specifics of 100 Patients/400 Hour Practicum

1. Attached to this form, have you included a coded log, which includes patient ID, age, gender, diagnosis, and time spent in treatment?
   ____YES ____NO

2. Have you also included with the form a log of the dates and times of Supervision?
   ____YES ____NO

3. Have you included a copy of the form you used to indicate to patients that you were under supervision?
   ____YES ____NO

4. Have you submitted to the Training Director two formal written evaluations completed by the primary supervisor?
   ____YES ____NO

5. Please describe the population parameters with whom you hope to practice with your conditional prescribing license (for example, only adults, only children, severely mentally ill, etc).

_____

_____

_____

_____

6. Please describe the range of disorders treated during your practicum experience.

_____

_____

_____

_____

_____

_____

7. How many of these were seen for acute conditions and chronic conditions.
   Acute _____ Chronic_____

8. In general terms, please provide evidence that you have seen a diverse set of patients throughout the lifecycle of various ethnicity and social/cultural backgrounds.

_____

_____

_____

9. Do you attest that the primary or secondary supervisor was on site?
   ____YES ____NO

10. Did your primary or secondary supervisor review charts and records?
    ____YES ____NO

11. Will you attest that there was at least one hour of supervision for every eight hours or direct service?
    ____YES ____NO

12. What was the date you began your practicum and completed your practicum?
    Begin_____ Ended_____

13. In evaluating your application, the Board of Psychologist Examiners reserves the right to request clinical records from the applicant or the Training Director. Do you certify, that if requested by the Board of Psychologist Examiners, you can and will make available to the Training Director of NMSU or the Board of Psychologist Examiners clinical records that support all of the experiences described above?
    ____YES ____NO

I, _____, swear or affirm under penalty of perjury under the laws of the State of New Mexico, that all forms requested are attached and that everything written above is complete and true.

Sworn this _____ day of _____, 20_____, at _____.
City and State

_____
Signature

STATE OF _____)
)
COUNTY OF _____)

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____, 20_____

SEAL

_____
Signature of Notary Public:_____
My Commission expires on:_____

Last But Not Least!

CHECKLIST OF MATERIAL TO BE SENT TO TRAINING DIRECTOR BEFORE APPLYING FOR YOUR CONDITIONAL PRESCRIBING LICENSE

_____ Copy of 80-Hour Practicum in a healthcare setting dated and signed by your supervising physician

_____ Copy of 100 patients/400 hours Practicum Plan

_____ Copy of form given to patients that they sign that explains you are a student in training

_____ Copy of your log for each of 100 patients seen in you 400-hour practicum

_____ Copy of your log which lists dates and times of supervision

_____ Copy of evaluations completed by your primary supervisor at the midpoint and end of practicum

_____ Copy of evaluation form completed by your secondary supervisor(s) of your practicum

_____ Copy of all your case notes with the identity and date blacked out or a notarized copy of the verification form that follows.

_____ It is also important for you to assure that your insurance carrier will cover you as a prescribing psychologist. The APA Insurance Trust has given their commitment to do so. If you have insurance coverage with a different carrier, it is strongly recommended that you write to them early on in your practicum to determine if they will cover you or if you need to seek another company

TRAINING PROGRAM VERIFICATION OF EXPERIENCE

Board of Psychologist Examiners
P. O. Box 25101• Santa Fe, New Mexico • 87505
(505) 476-4960

To the Training Director of a program of psychopharmacology

A. REQUEST FOR INFORMATION

The Board of Psychologist Examiners has received an application for a conditional certificate as a prescribing psychologist from the applicant named below. (To be filled out by Applicant and forwarded on to the Director of the training program)

Applicant:
Address:
City & State:
Telephone No.

Your name has been submitted by the applicant as a Director of the Training of that program. The Board has not received applicants from your program before. Therefore, we will need to complete an extensive review of the program to determine if it fulfills requirements of the New Mexico Prescribing Psychologist Act.

We would appreciate you providing the Board with the information requested and return this form and requested information directly to the Board office at the above address.

B. INFORMATION ABOUT THE TRAINING DIRECTOR

Training Director's Name: _____
Title and position of employment: _____
Institution of employment: _____
Address: _____
City & State: _____
Telephone No.: _____

Please describe your training in psychopharmacology:

_____
_____
_____
_____
_____
_____

Do you hold a license as a psychologist? Yes No

State: _____ Year license awarded: _____

Do you hold a license to prescribe psychotropics? Yes No

State: _____ Year license awarded: _____

Do you hold any other professional licenses in this or other jurisdictions? Yes No
Please list below:

State	**License Type**	**When awarded**

C. INFORMATION ABOUT THE PROGRAM

Does the applicant's psychopharmacology training meet the following criteria?

1. The program was an integrated program of study. Yes No

2. The program had an identifiable body of students at different levels of matriculation. Yes No

3. The program was clearly identified and labeled as a psychopharmacology Program and specified its intent to educate and train psychologists to Prescribe psychotropic medications. Yes No

4. The program had a formally designated program director who was a Psychiatrist or a doctoral psychologist trained in the area of Psychopharmacology and licensed to practice in the jurisdiction in Which the program resides. Yes No

5. The training director was primarily responsible for directing the training program and had administrative authority commensurate with those responsibilities. Yes No

6. The training director's credentials and expertise were consistent with the program's mission and goals to train psychologists to prescribe psychotropic medications Yes No

7. The program provided information regarding the minimum level of achievement required for postdoctoral trainees to satisfactorily progress

through and complete the training program, as well as evidence that it adhered to the minimum. Yes No

8. The program had formally designated instructors and supervisors in sufficient number to accomplish the program's education and training. Yes No

9. Supervisors held an active, unrestricted license in their field of practice in the jurisdiction in which the program resides or where the supervisor was being provided. Yes No

10. The program's supervisors and instructors had sufficient expertise, competence, and credentials in the areas in which they taught or supervised. Yes No

11. The program's instructors and supervisors participated actively in the program planning, implementation, and evaluation Yes No

12. The program, with appropriate involvement from its training supervisors, instructors, and trainees, engaged in a self-study process that addressed:

    A. Expectations for the quality and quantity of the trainees' preparation and performance in the program
    B. Training goals and objectives for the trainees and the trainees' views regarding the quality of the training experience and the program
    C. Procedures to maintain current achievements or to make changes as necessary
    D. Goals, objectives, and outcomes in relation to local, regional, and national changes in the knowledge base of psychopharmacology training

    Yes No

13. The program followed the guidelines for psychopharmacology training of postdoctoral psychologists established by the American Psychological Association. Yes No

14. Does the program include didactic instruction of no fewer than 450 classroom hours in at least the following core areas:
    - Neuroscience,
    - Pharmacology,
    - Psychopharmacology,
    - Physiology,
    - Pathophysiology
    - Appropriate and relevant physical assessment Clinical pharmacotherapeutics Yes No

15. The training program assures that every student completes necessary training in the basic sciences (physiology, chemistry, biochemistry, the biological bases of behavior, and psychopharmacology) Yes No

16. When students are not in residence, the program provides on-line access to a library of sufficient diversity and level to support the

advanced study of the psychopharmacological treatment of mental disorders from wherever the student resides. Access remains available throughout all didactic and clinical phases of the training program. Yes No

17. Frequent face-to-face evaluation and discussion are included in the didactic training. Yes No

18. The program provided formal, written, measurement of the mastery of the course content. Yes No

19. The program demonstrated in its written materials or course syllabi that integrates into the training the following areas: socio-cultural issues in psychopharmacological treatment, ethno-pharmacology, use of translators, the cultural context of compliance and non-compliance with prescribed medications, creating a culturally appropriate environment to meet patient care treatment and language needs, and working collaboratively with traditional healers. Yes No

D. SUBSTANTIATION

1. Please provide documentation that your program addresses the above requirements by providing as much of the following material as possible and checking below documentation forwarded to the Board.

_____ Program curriculum

_____ University Catalog Description

_____ Relevant Policy Manual

_____ Relevant Student Handbook

_____ Resume of Director

_____ Resumes of Faculty

_____ Evaluation of program by external experts or associations

2. Does the program maintain a website? Yes No
If so, please give url: _____

E. EVALUATION OF THE APPLICANT

1. Do you, as training director, certify that the applicant successfully completed didactic training as outlined above? Yes No

2. Eighty-Hour Practicum

SUPERVISOR

Name:

Address:

City & State:

Telephone No.

Describe the supervisor's area of practice in which he or she is formally trained and/or certified/licensed?

_____
_____
_____
_____
_____
_____

License #_____ State:_____ Date of Initial License_____

Was the 80-hour practicum part of the psychopharmacology Training program from which the applicant obtained His/her certification or degree? Yes No

Did your program receive an evaluation form about this applicant from this supervisor, which discusses the student's adequate development of skills in:

Assessing a diverse and significantly medically ill population Yes No

Observing the progression of illness and continuity of care of individual patients Yes No

Adequately assessing vital signs Yes No

Demonstrating competent laboratory assessment Yes No

Was the 80-hour practicum completed from full-time to over thirty weeks? Yes No

3. 400 Hour Practicum in Psychopharmacology

PRIMARY SUPERVISOR
Name:

Address:

City & State:

Telephone No.

Describe the supervisor's area of practice in which he or she is formally trained and/or certified/licensed.
_____
_____
_____
_____
_____
_____

License #_____ State:_____ Date of Initial License_____

SECONDARY SUPERVISOR 1

Name:

Address:

City & State:

Telephone No.

Describe the supervisor's area of practice in which he or she is formally trained and/or certified/licensed.
_____
_____
_____
_____
_____
_____

License #_____ State:_____ Date of Initial License_____

SECONDARY SUPERVISOR 2

Name:

Address:

City & State:

Telephone No.

Describe the supervisor's area of practice in which he or she is formally trained and/or certified/licensed.
_____
_____
_____
_____
_____
_____

License #_____ State:_____ Date of Initial License_____

SECONDARY SUPERVISOR 3

Name:

Address:

City & State:

Telephone No.

Describe the supervisor's area of practice in which he or she is formally trained and/or certified/licensed.
_____
_____
_____
_____
_____
_____

License #_____ State:_____ Date of Initial License_____

Was the 400-hour practicum part of the psychopharmacology training program from which the applicant obtained his/her certification or degree? Yes No

- Did the applicant submit a 400-hour practicum plan to the Practicum Director? Yes No
- Did the practicum meet the following requirements?

  A. A minimum of 100 separate patients? Yes No

  B. A range of disorders listed in the most recent DSM? Yes No

  C. Both acute and chronic conditions? Yes No

  D. 400 hours included time spent with patients to provide evaluation and pharmacotherapy, and time spent in collaboration with treating healthcare practitioners? Yes No

  E. Was there diversity, including gender, ages throughout the life cycle, various ethnicities, socio-cultural background, various economic backgrounds as much as possible within the psychologist's area of practice? Yes No

  F. Was the primary or secondary supervisor on-site? Yes No

  G. Did the primary/secondary supervisor(s) review charts and records? Yes No

  H. Was there at least one hour of supervision for every eight hours of direct service? Yes No

  I. Did the applicant keep a log of dates & times of supervision? Yes No

  I. Was the practicum completed in no less than 6 months and no more than three years? Yes No

  K. Was the practicum completed within the 5 years preceding this application? Yes No

  L. Is there evidence that during the initial contact with patients or guardians, the status of applicant as a licensed psychologist receiving specialized training in psychopharmacology and who is under supervision was Fully explained? Yes No

- Did the applicant and the training program keep records of time spent during the practicum? Yes No

- Does the program have a coded log, without patient ID, submitted by the applicant, which includes for each of the 100 patients: age, gender, diagnosis, and time spent in treatment Yes No

- Does the program have at least two formal written evaluations of the applicant, completed by the primary supervisor, for the practicum experience assessing progress, competence, and deficiencies? Yes No

- Did the supervisor(s) certify in writing that the applicant's performance was satisfactory for the practicum? Yes No

- Do you, as training director, certify that the applicant has adequately completed a 400-hour/100-patient practicum Yes No

4. Overall evaluation

1. I would rate this student's performance under my training:
   (Please circle one)

   Excellent Acceptable Not Acceptable Unable to Evaluate

2. REMARKS: The Board would appreciate any information regarding your evaluation in Item 1 above. Please include any information you consider to be relevant regarding the applicant.

As Director of Training, I certify that all of the statements made in this document are true, complete, and correct to the best of my knowledge and belief and are made in good faith.

_____
Signature of Training Director/Supervisor

_____
Date

Please mail directly to the Board Office upon completion:

New Mexico Board of Psychologist Examiners
P. O. Box 25101
Santa Fe, New Mexico 87505

State Board of Psychologist Examiners

CONDITIONAL PRESCRIBING PSYCHOLOGIST CERTIFICATE APPLICATION

VERIFICATION BY SUPERVISOR OF 80-HOUR PRACTICUM IN PRIMARY HEALTH CARE

PLEASE NOTE: to be completed by the supervisor

SUPERVISOR 80-HOUR PRACTICUM

The Board of Psychologist Examiners has received an application for a conditional certificate as a prescribing psychologist from the applicant named below. (To be filled out by Applicant and forwarded on to the Director of the training program)

Applicant:_____

Address:_____

City & State:_____

Telephone No._____

We would appreciate you providing the Board with the information requested and return this form directly to the Board office at the above address.

SUPERVISOR

Name:_____

Address:_____

City & State:_____

Telephone No._____

Describe the supervisor's area of practice in which he or she is formally trained and/or certified/licensed?

_____

NEW MEXICO LICENSURE

Is your medical license current and unrestricted? Yes ☐ No ☐

Date New Mexico medical license was issues:_____

License Number and Type of License:_____

State Board of Psychologist Examiners

CONDITIONAL PRESCRIBING PSYCHOLOGIST CERTICICATE APPLICATION

Do you hold any other professional licenses in this or any other jurisdiction? Please list below:

License No.	Type	State	Status (Active/Inactive)

Name and Address of Applicant's Training Director:_____

_____

Date Practicum Began:_____ Date Practicum Ended:_____

1. Have you sent an evaluation form about this applicant to the Director of Training discussing the student's adequate development of skills in:
   a. Assessing a diverse and significantly ill medical population? Yes ☐ No ☐
   b. Observing the progression of illness and continuity of care of individual patients? Yes No
   c. Adequately assessing vital signs? Yes ☐ No ☐
   d. Demonstrating competent laboratory assessment? Yes ☐ No ☐
   e. Demonstrating competence in physical and health assessment techniques? Yes ☐ No ☐

2. Has the student successfully completed the eighty-hours of supervised experience with you as specified in the Prescribing Psychologist Act? Yes ☐ No ☐

The Board would appreciate any comments you might have regarding this applicant's practicum. Please include any information you consider relevant regarding this applicant.

_____

_____

_____

_____

As the Clinical Supervisor of the 80-Hour Practicum, I certify that all of the statements made in this document are true, complete, and correct to the best of my knowledge and belief and are made in good faith.

_____

Signature of Clinical Supervisor

_____

Date

Please mail directly to the Board Office upon completion.
New Mexico Board of Psychologist Examiners
P. O. Box 25101
Santa Fe, New Mexico 87505

State Board of Psychologist Examiners
CONDITIONAL PRESCRIBING PSYCHOLOGIST CERTICICATE APPLICATION

CONDITIONAL PRESCRIBING PSYCHOLOGIST PROPOSED SUPERVISORY PLAN

PLEASE NOTE: To be completed by Supervisor(s)

NAME OF APPLICANT:_____

To be completed by: Primary Supervisor

Primary Supervisor Name:_____
Address:_____
City & State:_____
Telephone No.:_____

Please describe the area of practice in which you are formally trained and/or certified/licensed. If you are not a psychiatrist, please indicate your experience and training in prescribing psychotropic medications.

_____
_____
_____
_____

License No._____ State:_____ Date of Initial License:_____

Is your license current and unrestricted?	Yes	No

Do you have any other license in this or any other jurisdiction? If yes, explain below.	Yes	No

License No.	**Type**	**State**	**Status Active/Inactive**

State Board of Psychologist Examiners
CONDITIONAL PRESCRIBING PSYCHOLOGIST CERTICICATE APPLICATION

To be completed by: Secondary Supervisor

Secondary Supervisor Name:_____
Address:_____
City & State:_____
Telephone No.:_____

Please describe the area of practice in which you are formally trained and/or certified/licensed. If you are not a psychiatrist, please indicate your experience and training in prescribing psychotropic medications.

_____
_____
_____
_____

License No._____ State:_____ Date of Initial License:_____

Is your license current and unrestricted?	Yes	No

Do you have any other license in this or any other jurisdiction? If yes, explain below.	Yes	No

License No.	**Type**	**State**	**Status Active/Inactive**

To be completed by: Primary Supervisor

List beginning and end date(s) of the two-year supervised practice covered by the plan.
Approximate beginning date:_____ Ending date:_____

List the setting(s) in which the conditional prescribing psychologist will practice and the hours per week worked at each setting._____
_____
_____

List duties and clinical responsibilities of the conditional prescribing psychologist._____
_____
_____
_____

State Board of Psychologist Examiners
CONDITIONAL PRESCRIBING PSYCHOLOGIST CERTICICATE APPLICATION

List location(s) where the supervision will occur and with whom._____

List areas in which the primary and secondary supervisor(s), if any, have specialized skills to render competent supervision._____

List the number and name of the psychologists with conditional prescription certificates that you will be supervising during this time period:_____

Describe the manner in which the conditional prescribing psychologist will be represented to the public, including all written communications and public announcements. (Please enclose copies of any printed materials.)_____

	Yes	No
Is there any direct or indirect financial agreement between or among the conditional prescribing psychologist and the primary and secondary supervisor(s)? If yes, please describe the agreement on a separate page.		

Describe and other information necessary to clarify the nature and scope of the supervision._____

Provide a statement specifying the manner in which supervision and clinical and professional responsibility will be provided during the supervisor's absence (during vacations or unexpected events that require that supervisor to be absent for any period of time)._____

	Yes	**No**
As the primary supervisor, will you provide supervision on a one-to-one basis for at least 4 hours per month and a total of at least 46 hours of one-to-one supervision per year?		

	Yes	**No**
As the supervising physician, will you have access to and review records relating to the treatment of patients under his/her supervision?		

As the primary supervisor will you contact any secondary supervisor(s) at least every six months to obtain written or verbal progress reports concerning how the prescribing psychologist is performing?	**Yes**	**No**
Will the supervision be provided either face-to-face, telephonically, or by tele-video live communication?	**Yes**	**No**
Will you, as primary supervisor, inform any secondary supervisor(s) of any concerns about the conditional prescribing psychologist's performing?	**Yes**	**No**
Will you maintain a supervision log containing dates, duration, and place/method of supervision, the same identification code for patients as used by the psychologist with a conditional prescribing certificate, and a brief description of the content of supervision?	**Yes**	**No**
Will you, as primary supervisor, maintain a log of contacts with the secondary supervisor(s)?	**Yes**	**No**
Will you review the results of laboratory tests as appropriate?	**Yes**	**No**

PRIMARY SUPERVISOR AGREEMENT

I, as a licensed physician, knowledgeable of the administration of psychotropic medications, agree to supervise Dr. _____. He/She holds a conditional certificate as a prescribing psychologist.

I have read the above document and agree to comply with the terms and conditions as described above. I understand that the supervisory plan may be modified if I deem appropriate by submitting to the application committee for its approval, a modified plan agreed to be me, any secondary supervisors, and the conditional prescribing psychologist. The intent of my modified plan would be to best reflect the psychologist's needs for supervision.

_____ _____

Signature of Supervisor Date

_____ _____

Signature of Psychologist Supervisee Date

State Board of Psychologist Examiners
CONDITIONAL PRESCRIBING PSYCHOLOGIST CERTICICATE APPLICATION

SECONDARY SUPERVISOR AGREEMENT

Please complete this form for each Secondary Supervisor. Make copies as needed.

Secondary Supervisor

Will you, as secondary supervisor, inform the primary supervisor of any concerns about the conditional prescribing psychologist you are supervising?	**Yes**	**No**
Will you maintain a supervision log containing dates, duration, place/method of supervision, the same identification code for patients as used by the conditional prescribing psychologist and a brief description of the content of supervision?	**Yes**	**No**
Will you review the results of laboratory tests as appropriate?	**Yes**	**No**

I, _____, a licensed physician and secondary supervisor, agree to supervise Dr. _____, who holds a conditional certificate as a prescribing psychologist. I have read the above document and agree to comply with the terms and conditions described above.

_____ _____
Signature Date

_____ _____
Signature of Psychologist Supervisee Date

Mail to:
New Mexico State Board of Psychologist Examiners
P.O. Box 25101
Santa Fe, NM 87505

Section 3. Section 61-9-1 NMSA 1978 (being Laws 1963, Chapter 92, Section 1) is amended to read:

"61-9-1. SHORT TITLE.-[This act] Chapter 61, Article 9 NMSA 1978 may be cited as the "Professional Psychologist Act"."

Section 4. Section 61-9-3 NMSA 1978 (being Laws 1963, Chapter 92, Section 3, as amended) is amended to read:

"61-9-3. DEFINITIONS.-As used in the Professional Psychologist Act:

A. "board" means the New Mexico state board of psychologist examiners;

B. "conditional prescription certificate" means a document issued by the board to a licensed psychologist that permits the holder to prescribe psychotropic medication under the supervision of a licensed physician pursuant to the Professional Psychologist Act;

[B.] C. "person" includes an individual, firm, partnership, association or corporation;

D. "prescribing psychologist" means a licensed psychologist who holds a valid prescription certificate;

E. "prescription certificate" means a document issued by the board to a licensed psychologist that permits the holder to prescribe psychotropic medication pursuant to the Professional Psychologist Act;

F. "psychotropic medication" means a controlled substance or dangerous drug that may not be dispensed or administered without a prescription and whose primary indication for use has been approved by the federal food and drug administration for the treatment of mental disorders and is listed as a psychotherapeutic agent in drug facts and comparisons or in the American hospital formulary service;

C.] G. "psychologist" means [any] a person who engages in the practice of psychology or holds himself out to the public by any title or description of services representing himself as a psychologist, which incorporates the words "psychological", "psychologist", "psychology", or when a person describes himself as above and, under such title or description, offers to render or renders services involving the application of principles, methods and procedures of the science and profession of psychology to persons for compensation or other personal gain;

[D.] H. “practice of psychology” means the observation, description, evaluation, interpretation and modification of human behavior by the application of psychological principles, methods and procedures for the purpose of preventing or eliminating symptomatic, maladaptive or undesired behavior and of enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health and mental health, and further means the rendering of such psychological services to individuals, families or groups regardless of whether payment is received for services rendered. The practice of psychology includes psychological testing or neuropsychological testing and the evaluation or assessment of personal characteristics such as intelligence, personality, abilities, interests, aptitudes and neuropsychological functioning; counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, behavior analysis and therapy; diagnosis and treatment of any mental and emotional disorder or disability, alcoholism and substance abuse, disorders of habit or conduct and the psychological aspects of physical illness, accident, injury and disability; and psychoeducational evaluation, therapy, remediation and consultation; and

[E.] I. “school” or “college” means [any] a university or other institution of higher education that is regionally accredited and that offers a full-time graduate course of study in psychology as defined by rule of the board or that is approved by the American psychological association.”

Section 5. Section 61-9-17 NMSA 1978 (being Laws 1963, Chapter 92, Section 16, as amended) is amended to read:

“61-9-17. DRUGS-MEDICINES.-[Nothing in the Professional Psychologist Act shall be construed as permitting psychologists or psychologist associates licensed under the Professional Psychologist Act to]

A. Except as provided in Subsections B and C of this section, psychologists or psychologist associates shall not administer or prescribe drugs or medicine or in any manner engage in the practice of medicine as defined by the laws of this state.

B. A licensed psychologist holding a conditional prescription certificate may prescribe psychotropic medication under the supervision of a licensed physician pursuant to the Professional Psychologist Act.

C. A prescribing psychologist may prescribe psychotropic medication pursuant to the Professional Psychologist Act.”

Section 6. A new section of the Professional Psychologist Act is enacted to read:

"[NEW MATERIAL] CONDITIONAL PRESCRIPTION CERTIFICATE-PRESCRIPTION CERTIFICATE-APPLICATION-REQUIREMENTS-RULEMAKING BY BOARD-ISSUANCE, DENIAL, RENEWAL AND REVOCATION OF CERTIFICATION.-

A. A psychologist may apply to the board for a conditional prescription certificate. The application shall be made on a form approved by the board and be accompanied by evidence satisfactory to the board that the applicant:

(1) has completed a doctoral program in psychology from an accredited institution of higher education or professional school, or, if the program was not accredited at the time of the applicant's graduation, that the program meets professional standards determined acceptable by the board;

(2) holds a current license to practice psychology in New Mexico;

(3) has successfully completed pharmacological training from an institution of higher education approved by the board or from a provider of continuing education approved by the board;

(4) has passed a national certification examination approved by the board that tests the applicant's knowledge of pharmacology in the diagnosis, care and treatment of mental disorders;

(5) within the five years immediately preceding the date of application, has successfully completed an organized program of education consisting of intensive didactic instruction of no fewer than four hundred fifty classroom hours in at least the following core areas of instruction:

a) neuroscience;

(b) pharmacology;

(c) psychopharmacology;

(d) physiology;

(e) pathophysiology;

(f) appropriate and relevant physical and laboratory assessment; and

(g) clinical pharmacotherapeutics;

(6) within the five years immediately preceding the date of application, has been certified by the applicant's supervising psychiatrist or physician as having successfully completed a supervised and relevant clinical experience of no less than an eighty-hour practicum in clinical assessment and pathophysiology and an additional supervised practicum of at least four hundred hours treating no fewer than one hundred patients with mental disorders, the practica to have been supervised by a psychiatrist or other appropriately trained physician and determined by the board to be sufficient to competently train the applicant in the treatment of a diverse patient population;

(7) has malpractice insurance in place that will cover the applicant during the period the conditional prescription certificate is in effect; and

(8) meets all other requirements, as determined by rule of the board, for obtaining a conditional prescription certificate.

B. The board shall issue a conditional prescription certificate if it finds that the applicant has met the requirements of Subsection A of this section. The certificate shall be valid for a period of two years, at the end of which the holder may again apply pursuant to the provisions of Subsection A of this section. A psychologist with a conditional prescription certificate may prescribe psychotropic medication under the supervision of a licensed physician subject to the following conditions:

(1) the psychologist shall continue to hold a current license to practice psychology in New Mexico and continue to maintain malpractice insurance;

(2) the psychologist shall inform the board of the name of the physician under whose supervision the psychologist will prescribe psychotropic medication and promptly inform the board of any change of the supervising physician; and

(3) a physician supervising a psychologist prescribing psychotropic medication pursuant to a conditional prescription certificate shall be individually responsible for the acts and omissions of the psychologist while under his supervision. This provision does not relieve the psychologist from liability for his acts and omissions.

C. A psychologist may apply to the board for a prescription certificate. The application shall be made on a form approved by the board and be accompanied by evidence satisfactory to the board that the applicant:

(1) has been issued a conditional prescription certificate and has successfully completed two years of prescribing psychotropic medication as certified by the supervising licensed physician;

(2) holds a current license to practice psychology in New Mexico;

(3) has malpractice insurance in place that will cover the applicant as a prescribing psychologist; and

(4) meets all other requirements, as determined by rule of the board, for obtaining a prescription certificate.

D. The board shall issue a prescription certificate if it finds that the applicant has met the requirements of Subsection C of this section. A psychologist with a prescription certificate may prescribe psychotropic medication pursuant to the provisions of the Professional Psychologist Act if the psychologist:

(1) continues to hold a current license to practice psychology in New Mexico and continues to maintain malpractice insurance; and

(2) annually satisfies the continuing education requirements for prescribing psychologists, as set by the board, which shall be no fewer than twenty hours each year.

E. The board shall promulgate rules providing for the procedures to be followed in obtaining a conditional prescription certificate, a prescription certificate and renewals of a prescription certificate. The board may set reasonable application and renewal fees.

F. The board shall promulgate rules establishing the grounds for denial, suspension or revocation of conditional prescription certificates and prescription certificates authorized to be issued pursuant to this section, including a provision for suspension or revocation of a license to practice psychology upon suspension or revocation of a certificate. Actions of denial, suspension or revocation of a certificate shall be in accordance with the Uniform Licensing Act."

Section 7. A new section of the Professional Psychologist Act is enacted to read:

"[NEW MATERIAL] PRESCRIBING PRACTICES.-

A. A prescribing psychologist or a psychologist with a conditional prescription certificate may administer and prescribe psychotropic medication within the recognized scope of the profession, including the ordering and review of laboratory tests in conjunction with the prescription, for the treatment of mental disorders.

B. When prescribing psychotropic medication for a patient, the prescribing psychologist or the psychologist with a conditional prescription certificate shall maintain an ongoing collaborative relationship with the health care practitioner who oversees the patient's general medical care to ensure that necessary medical

examinations are conducted, the psychotropic medication is appropriate for the patient's medical condition and significant changes in the patient's medical or psychological condition are discussed.

C. A prescription written by a prescribing psychologist or a psychologist with a conditional prescription certificate shall:

(1) comply with applicable state and federal laws;

(2) be identified as issued by the psychologist as "psychologist certified to prescribe"; and

(3) include the psychologist's board-assigned identification number.

D. A prescribing psychologist or a psychologist with a conditional prescription certificate shall not delegate prescriptive authority to any other person. Records of all prescriptions shall be maintained in patient records.

E. When authorized to prescribe controlled substances, a prescribing psychologist or a psychologist with a conditional prescription certificate shall file with the board in a timely manner all individual federal drug enforcement agency registrations and numbers. The board shall maintain current records on every psychologist, including federal registrations and numbers.

F. The board shall provide to the board of pharmacy an annual list of prescribing psychologists and psychologists with conditional prescription certificates that contains the information agreed upon between the board and the board of pharmacy. The board shall promptly notify the board of pharmacy of psychologists who are added or deleted from the list.

G. For the purpose of this section:

(1) "collaborative relationship" means a cooperative working relationship between a prescribing psychologist or a psychologist with a conditional prescription certificate and a health care practitioner in the provision of patient care, including diagnosis and cooperation in the management and delivery of physical and mental health care; and

(2) "health care practitioner" means a physician, osteopathic physician or nurse practitioner."

Section 8. EFFECTIVE DATE.-The effective date of the provisions of this act is July 1, 2002.