SAMPLE Opioid Treatment Report

Print

Initial 90 Day Evaluation

Patient Name: _____ DOB:____/_____/_____

DOI:_____/_____/_____ Claim #: _____

Date Opioid Treatment Started: _____/_____/_____ Current MED Level_____

Number of Days since Opioids Treatment Started: _____(calendar days)

Prior Medical Treatment to Date:

Date Automated Prescription Drug Monitoring Program (MAPS) Obtained: _____/_____/_____

MAPS Results: Compliant ☐ Non-Compliant ☐ Other_____

Non-Opioid Pain Management Treatment to Date and its Effectiveness or Contraindication :

Current Treatment Goal, Functional Progress and Consideration for Weaning:

Risk Screening Tool Used: Yes ☐ No ☐ Date completed _____/_____/_____

Risk Screening Tool Results: (check one) Low ☐ Medium ☐ High ☐

Date Urine Drug Screen Obtained: _____/_____/_____

Urine Drug Screen Result: Compliant ☐ Non-Compliant ☐

Report Attached: Yes ☐ No ☐

Date Patient Opioid Treatment Agreement Reviewed and Signed: _____/_____/_____

Physician Signature_____ Date _____/_____/_____

SAMPLE Opioid Treatment Report

Follow Up 90 Day Evaluation

Patient Name: _____ DOB:____/_____/_____

DOI:_____/_____/_____ Claim #_____

Date Opioid Treatment Started: _____/_____/_____ Current MED Level_____

Number of Days since Opioids Treatment Started: _____(calendar days)

Current Pain Management Treatment Plan:_____

Current Pain Management Treatment Plan Effectiveness and Functional Progress to Date:

MAPS Results: Compliant ☐ Non-Compliant ☐ Other_____

Date Automated Prescription Drug Monitoring Program (MAPS) Last Obtained: _____/_____/_____

Date Urine Drug Screen Obtained: _____/_____/_____

Urine Drug Screen Results:_____

Date Patient Opioid Treatment Agreement Reviewed and Signed: _____/_____/_____

Physician Signature_____ Date _____/_____/_____