



Opiate Replacement Therapy Report

Month Submitted for: _____

Date: _____ Date of Last Visit: _____

Client: _____ Provider: _____

Facility Name: _____

Phone Number: _____ Fax Number: _____

The individual listed above is a Healthcare Professional being monitored by Peer Assistance Services, Inc (PAS.) The program requires clinical information as part the individual's assessment process and his/her rehabilitation and monitoring plan.

If the client's medical condition requires the use of Opiate Replacement Therapy:

- The client must see a provider on a regular basis for on-going evaluation.
- The provider must also submit an Opiate Replacement Therapy Report to the PAS Case Manager at a frequency determined by the Case Manager.

1) What prescriptions/controlled medications are you currently prescribing for this individual?

<u>Medication Name</u>	<u>Dosage</u>	<u>Frequency</u>

2) What is the diagnosis that requires treatment with these medications? _____

3) What other treatments, both pharmacological and non-pharmacological, have been attempted? _____

4) What were the outcomes of these treatments? _____

Email: reports@peerassist.org

Reports may be submitted via:

Fax: Last name A-L 720.213.1007
Last Name M-Z 720.213.0002

Mail: Peer Assistance Services
2170 S. Parker Road, Suite 229
Denver, CO 80231

In Person: Peer Assistance Services, Inc.
2170 S. Parker Road, Suite
229
Denver, CO 80231

or Peer Assistance Services, Inc.
200 Grand Avenue, Suite 270
Grand Junction, CO 81501

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Continued

Client: _____

5) Is treatment with this medication(s) the only effective treatment for the individual's condition? (If yes, please explain) _____

6) How long do you anticipate that the individual will need to use this medication? _____

7) Has client expressed craving for opioids, besides the opiate replacement therapy? (If yes, please explain) _____

8) Is a urine drug screen administered during each office visit? _____

9) Is there any evidence of prescription/controlled medication abuse? _____

10) Has the client's history of controlled substance prescriptions been reviewed in the Prescription Drug Monitoring Program (PDMP)? Is the client using additional opioids besides the opiate replacement therapy? Please explain. _____

11) Do you have any concerns about the licensee's ability to perform the following tasks in the work-place:

- | | | |
|---|------------------------------|-----------------------------|
| • Think critically, plan, organize, and prioritize. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Remember and concentrate. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Communicate effectively with health care team members. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Develop and maintain a therapeutic provider-patient relationship. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Respond appropriately to an emergency in the work place. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If "yes," please explain _____

Additional Comments: _____

Provider Signature: _____

Date: _____

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