OPIOID MANAGEMENT REPORT

Date: **Patient name:**

Date of birth: **Date of test:** **Specimen number:**

Reason for ordering of the test

Drug test prior to initial long term drug prescription	Yes ☐	No ☐
Follow up (at least annually)	Yes ☐	No ☐
Concern regarding functional status of the patient	Yes ☐	No ☐
Abnormal results on previous testing	Yes ☐	No ☐
Change in management of dosage or pain	Yes ☐	No ☐
Chronic daily opioid dosage above 50 mg morphine or equivalent	Yes ☐	No ☐

Medication side effects: fatigue: ☐ constipation: ☐ cognitive problems: ☐ other: ☐

Results of opioid Testing

Results: expected ☐ not expected ☐

Results of <u>other</u> medication testing:

Results: expected ☐ not expected ☐

PDMP results reviewed:

Results: medications: expected ☐ not expected ☐

Benzodiazepine use: Yes ☐ No ☐

single provider ☐ multiple providers ☐

Reviewing of the medical records:

Level of functioning:

Past and current functional status for:

Work: increased ☐ decreased ☐ same ☐

Leisure activities: increased ☐ decreased ☐ same ☐

Activities of daily living: increased ☐ decreased ☐ same ☐

Discussion of:

Opioid screening results:

Other laboratory testing:

PDMP:

Medication side effects:

Level of functioning:

Describe what actions, if any, need to be taken:

(Provided courtesy of Dr. Hugh Macaulay)