Opiate Replacement Therapy Report

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?

Medication Name	Dosage	Frequency

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?

Mail or Fax Original To:

Metro Denver, Northern and Southern:

Peer Assistance Services, Inc.
2170 S. Parker Road, Suite 229
Denver, CO 80231
Phone: 303.369.0039 or 866.369.0039
Fax: 720.213.1007 or 720.213.0002

Western Slope NURSE Clients Only:

Peer Assistance Services, Inc.
200 Grand Avenue, Suite 260
Grand Junction, CO 81501
Phone: 970.986.4360
Fax: 970.241.9094

Opiate Replacement Therapy Report
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 opiods, besides the opiate replacement therapy? (If yes, please explain)

8) Is a urine drug screen administered during each office visit? ☐ YES ☐ NO

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 opiods 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. ☐ Yes ☐ No
- Remember and concentrate. ☐ Yes ☐ No
- Communicate effectively with health care team members. ☐ Yes ☐ No
- Develop and maintain a therapeutic provider-patient relationship. ☐ Yes ☐ No
- Respond appropriately to an emergency in the work place. ☐ Yes ☐ No

If "yes," please explain:

Additional Comments:

Provider Signature: ________________________________ **Date:** ______________________

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