

Opioid Prescription Documentation Form



Encounter Reason: High Risk Drug Monitoring	
Patient Name:	Medication:
DOB:	Rx #:
Medication Related Problem	Intervention
<input type="checkbox"/> Medication dose too high	<input type="checkbox"/> Pain Medication Review

Notes:

Use (circle one): Acute / Chronic

Opioid Indication: _____

MME: _____

PDMP Check on _____ by _____

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