Medical Management Visit Form

Patient's Name: _____ **ID#**_____

Date: _____ **Week#:** _____ **Dose:** _____ mg ☐ No Show

Heroin/cocaine or other illicit drug use since last visit?

_____

Symptoms or signs that might indicate return to use (e.g., changes in mood, physical appearance)?

_____

Since the last visit, are there any problems with the following:

			If yes, explain
Drug Use	☐ Yes	☐ No	_____
Alcohol Use	☐ Yes	☐ No	_____
Psychiatric	☐ Yes	☐ No	_____
Medical	☐ Yes	☐ No	_____
Employment	☐ Yes	☐ No	_____
Social/Family	☐ Yes	☐ No	_____
Legal	☐ Yes	☐ No	_____

Any new problem to add to Treatment Plan Review? ☐ Yes ☐ No

_____

Plan to address any new problem _____

_____

Participation in Narcotics Anonymous or Alcoholics Anonymous since last visit? ☐ Yes ☐ No

Length of Session: _____ Healthcare Professional Signature: _____

D. Fiellin, December 3, 2016 (personal communication). Adapted with permission.