

Participant's Name: _____

DOB: _____



MEDICATION REPORT FORM

DIRECTIONS: To be completed and signed by the PRESCRIBING PHYSICIAN, then returned to the AMF by fax, mail or secure email.*

MEDICATION INFORMATION (prescription and non-prescription) Please use back or attach extra pages if needed to list all medications.

Prescription Date	Medication/Dose	Quantity	Refills	Diagnosis/Reason for prescription

PRESCRIBING PHYSICIAN QUESTIONNAIRE:

- 1. Disclosure:** Did the patient inform you that they are currently in recovery, being monitored by the AMF, and have a diagnosed substance use disorder and/or mental health condition? Yes No
- 2. Prescribing Controlled Substances:** If you are prescribing opioids or other medications with abuse potential/risk (Schedule II–V drugs), please confirm the following:
____ You are aware of the patient’s history of substance use.
____ You have discussed and evaluated the potential risks and benefits of this treatment with the patient.
____ You believe this is the most appropriate course of treatment for the patient at this time.
- 3.** How long do you anticipate the patient will require this medication? _____
- 4. Do you feel that your patient is safe to practice in his/her profession competently while taking this/these medication(s):** Yes No
○ If “NO” please explain: _____

PRESCRIBING PHYSICIAN INFORMATION:

Name: _____ Credentials: _____

Name of Facility/Practice: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____ Email: _____

Signature: _____ Date: _____

**This form is acceptable ONLY if provided directly to the AMF by the prescriber.*