Case Presentation Template

Opioid Review and MAT Clinic
Kurt DeVine, MD and Heather Bell, MD

Date: _____ Your Name: _____ ECHO ID #_____

Patient Type: ☐ New Patient ☐ Follow- Up Age: _____ Ethnicity: _____

Distance to your clinic from patient's home: _____ Gender: _____

Occupation: _____ Education Level: _____

Height: _____ Weight: _____ BMI: _____

Alcohol Use: ☐ Yes ☐ No Amount: _____

Pertinent Comorbidities? ☐ Yes ☐ No

Diagnosis: _____

Medication Agreement/Care Plan signed: ☐ Yes ☐ No If yes, date: _____

Anxiety: ☐ Yes ☐ No Depression: ☐ Yes ☐ No

Other Mental Health Issues: _____

Pill Counts: _____

PMP Reviewed: ☐ Yes ☐ No Findings: _____

Social History: _____

Social Needs Identified: _____

Family History of Substance Abuse/Mental Illness: _____

_____

Legal Issues: _____

Previous Drug Treatment: _____

	Results	Dates
Pertinent UDAS Urine Drug Screen		
Pertinent Imaging Results		
Prior Surgical Interventions		
Prior Injections		
Prior Failed Treatments		
Prior Failed Medications		
Current Medications *with morphine equivalents*		
Other		

What is your main question about this patient? Other drug story/patient background information.

E-Mail or Fax Completed form to:
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