BEHAVIORAL HEALTH SYSTEMS

MEDICATION MANAGEMENT

(Return Via Fax to **: 205-879-1178**)

PATIENT NAME: ________________________________ PROVIDER NAME: ______________________________

INSURED'S EMPLOYER: ______________________________

The purpose of this report is to identify patient's current status, with regard to medications. HIPAA allows release of this information for payment purposes.

Date: _____/_____/_____

◇ DX: ______________________________ ◇ Next Office Visit: ________________

◇ Current Medication(s): ____

◇ Changes in medications? (New meds, discontinued meds): ☐ No ☐ Yes
List, if applicable: ____

◇ Patient Compliant with Medications? ☐ No ☐Yes Patient Stable: ☐ No ☐Yes

◇ Comments: ____

Completed by Physician ☐ Designee / Nurse ☐ ______________________________
SIGNATURE

Date: _____/_____/_____

◇ DX: ______________________________ ◇ Next Office Visit: ________________

◇ Current Medication(s): ____

◇ Changes in medications? (New meds, discontinued meds): ☐ No ☐ Yes
List, if applicable: ____

◇ Patient Compliant with Medications? ☐ No ☐Yes Patient Stable: ☐ No ☐Yes

◇ Comments: ____

Completed by Physician ☐ Designee / Nurse ☐ ______________________________
SIGNATURE

Date: _____/_____/_____

◇ DX: ______________________________ ◇ Next Office Visit: ________________

◇ Current Medication(s): ____

◇ Changes in medications? (New meds, discontinued meds): ☐ No ☐ Yes
List, if applicable: ____

◇ Patient Compliant with Medications? ☐ No ☐Yes Patient Stable: ☐ No ☐Yes

◇ Comments: ____

Completed by Physician ☐ Designee / Nurse ☐ ______________________________
SIGNATURE