# Workers' Compensation
# Controlled Substance Form

**Return completed application to the Third-Party Administrator**
**American Mining Claims Service**
**PO Box 660988**
**Birmingham, AL 35266-0988**

Date:
Claimant Name:
Claim Number:
Claimant SSN:
Date of Injury:
Vendor Number:
Physician Number:

1. What diagnosis is responsible for the claimant's pain:

2. Body Part:

3. Is the claimant's pain:
☐ Acute ☐ Chronic ☐ Intractable ☐ Psychogenic ☐ Neurogenic

Physician's Name and Address:

4. Does the claimant have a history of drug or alcohol abuse?
☐ Yes ☐ No If yes, please explain:

5. Does the claimant have a chronic illness or disease not related to the compensable injury that could be responsible for the chronic pain? ☐ Yes ☐ No If yes, explain:

6. Are there any medical conditions not related to the compensable injury that may require further treatment? ☐ Yes ☐ No If yes, briefly explain:

7. Are there any psychological factors to consider?
☐ Yes ☐ No If yes, briefly explain:

8. Was there a psychological condition prior to this injury?
☐ Yes ☐ No If yes, briefly explain:

9. Is there a detailed history of the pain phenomena? ☐ Yes ☐ No If yes, please complete the following:

Onset: _____ Duration: _____ Radiation: _____ Location: _____ Severity: _____

Level of pain using scale _____ (Pre Analgesia) Level of pain using scale _____ (Post Analgesia)
Treatment or activities other than medications that relieve pain:

10. The following medications and/or treatment/therapies have been prescribed:

| | | |
|---|---|---|
| ☐ NSAIDS | ☐ Improved | ☐ Not Improved |
| ☐ Muscle Relaxants | ☐ Improved | ☐ Not Improved |
| ☐ Steroids | ☐ Improved | ☐ Not Improved |
| ☐ Opioids | ☐ Improved | ☐ Not Improved |
| ☐ Physical Medicine | ☐ Improved | ☐ Not Improved |
| ☐ Injections | ☐ Improved | ☐ Not Improved |

11. Have you made an attempt to decrease the Opioid dosage?
☐ Yes ☐ No If yes, when and at what intervals?

If no, why?

12. On what <u>objective</u> findings do you base the need for continued Opioid therapy?

13. Have you referred the claimant for any consultations with other healthcare providers? ☐ Yes ☐ No

If yes, with whom? _____ Specialty _____ Recommendations_____
_____ _____ _____
_____ _____ _____

14. Have you discussed with the claimant the risks and side effects involved in long-term Opioid therapy? ☐ Yes ☐ No
Do you have a signed statement from the claimant showing his/her understanding? ☐ Yes ☐ No If yes, please enclose a copy.

15. How do you rate the claimant's potential to return to his/her preinjury employment position? ☐Excellent ☐Good ☐Fair ☐Poor

16. Have you performed any random testing to ensure that the claimant is taking the Opioid as prescribed? ☐ Yes ☐ No
What were the results?

17. Does the claimant's pain inhibit or interfere with his/her ability to perform ADL's? ☐ Yes ☐ No If yes, please describe his/her limitations:

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law, specifically §61-3-24G, provides for severe penalties if I knowingly certify a false report or statement, withhold material facts or statement, or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge my contractual obligations to American Mining Claims Service, the third-party administrator (TPA), and agree to release any office notes and test results immediately to American Mining Claims Service, the TPA.

**Comments:**

Physician Signature: _____ Date: _____