Workers' Compensation
Controlled Substance Form

Please return completed form to the applicable entity regarding this claim.
(Private Carrier, Self-Insured, or Third Party Administrator (TPA) administering this claim)

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 objective 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 pre-injury 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 the private carrier, self-insured, or the TPA administering this claim, and I agree to release any office notes and test results immediately the private carrier, self-insured, or the TPA administering this claim.

Comments:

Physician Signature:_____ Date: _____