Controlled Substance Follow-Up Report

Return completed form to:

BrickStreet Mutual Insurance
P.O.Box 3151
Charleston, West Virginia 25332-3151

Claimant Name:	Date:
Claim Number:	Vendor Number:
Claimant SSN:	Physician's Phone Number:
Date of Injury:	

Physician's Name and Address:

1. Date of this exam:

2. What diagnosis is responsible for the claimant's pain?

3. Body part involved:

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

5. Please indicate all controlled substances that this claimant is receiving:

Drug Name	Dosage	Frequency

6. Please indicate if there have been any changes or reductions in opioids within the last 30 days.

7. Is the claimant receiving controlled substances from any other physicians? ☐ Yes ☐ No If yes, please list drugs and prescribing physician.

Drug:	Physician:
Drug:	Physician:
Drug:	Physician:

8. Please indicate **key objective** findings upon which you base your decision to continue prescribing controlled substances.

9. In your opinion, what is the estimated length of time this claimant will require the use of the currently prescribed controlled substances?

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 fact 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 BrickStreet Insurance and agree to release any office notes and test results immediately to BrickStreet Insurance.

Physician Signature: **Date:** / /