



Medical Management Visit Form

Patient's Name: _____ ID# _____

Date: _____ Week#: _____ Dose: _____ mg No Show

Heroin/cocaine or other illicit drug use since last visit?

Symptoms or signs that might indicate return to use (e.g., changes in mood, physical appearance)?

Since the last visit, are there any problems with the following:

If yes, explain

Drug Use Yes No

Alcohol Use Yes No

Psychiatric Yes No

Medical Yes No

Employment Yes No

Social/Family Yes No

Legal Yes No

Any new problem to add to Treatment Plan Review? Yes No

Plan to address any new problem _____

Participation in Narcotics Anonymous or Alcoholics Anonymous since last visit? Yes No

Length of Session: _____ Healthcare Professional Signature: _____

D. Fiellin, December 3, 2016 (personal communication). Adapted with permission.