The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
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Pharmacy Substance Use Disorder (PSUD) Program
HEALTH CARE/MEDICATION REPORT

Please complete this form with current information and return it directly to the PSUD participant.

Name of PSUD Participant: _____

Dates of Treatment: _____

Diagnosis: _____

Treatment: _____

PRESCRIPTION INFORMATION			
medication	*date prescribed*	*quantity & dosage number of refills*	*precipitating symptom*

(Please attach a separate sheet if there is not enough room)

I have been informed this patient is in recovery for alcohol and/or chemical dependency.

☐ Yes ☐ No Comments:

Other Medical Recommendations:

Other comments:

_____ _____

Name of Practitioner (please print) Agency (if applicable)

_____ _____

Contact Information License #

Duration of treatment relationship with PSUD participant: _____

_____ _____

Signature of Practitioner Report Date

(Please attach a separate sheet if there is not enough room)