MEDICATION MANAGEMENT

(Return Via Fax to : **205-879-1178**)

PATIENT NAME: ______________________________ PROVIDER NAME: ____________________________

INSURED'S EMPLOYER: ___________________________

The purpose of this report is to identify patient's current status, with regard to medications. HIPAA allows release of this information for payment purposes.

Date: _____/_____/_____	♬ DX: ____________________ ♬ Next Office Visit: ______________ ♬ Current Medication(s): ______________________________ ♬ Changes in medications? (New meds, discontinued meds): ☐ No ☐ Yes List, if applicable: ______________________ ♬ Patient Compliant with Medications? ☐ No ☐Yes Patient Stable: ☐ No ☐Yes ♬ Comments: ______________________________ Completed by Physician ☐ Designee / Nurse ☐ ______________________ SIGNATURE

Date: _____/_____/_____	♬ DX: ____________________ ♬ Next Office Visit: ______________ ♬ Current Medication(s): ______________________________ ♬ Changes in medications? (New meds, discontinued meds): ☐ No ☐ Yes List, if applicable: ______________________ ♬ Patient Compliant with Medications? ☐ No ☐Yes Patient Stable: ☐ No ☐Yes ♬ Comments: ______________________________ Completed by Physician ☐ Designee / Nurse ☐ ______________________ SIGNATURE

Date: _____/_____/_____	♬ DX: ____________________ ♬ Next Office Visit: ______________ ♬ Current Medication(s): ______________________________ ♬ Changes in medications? (New meds, discontinued meds): ☐ No ☐ Yes List, if applicable: ______________________ ♬ Patient Compliant with Medications? ☐ No ☐Yes Patient Stable: ☐ No ☐Yes ♬ Comments: ______________________________ Completed by Physician ☐ Designee / Nurse ☐ ______________________ SIGNATURE