Unexpected Drug Screen Result
Documentation Form

Patient Name: _____ Date of Visit: _____

Date of Birth: _____

1. The patient's urine drug screen results indicates:

☐ The presence of a non-prescribed or illicit controlled substance.

☐ The absence of a prescribed controlled substance.

2. I have discussed this situation with the patient and we have reached the following conclusions:

☐ The patient denies the result. The sample will be sent for quantitative confirmation testing and upon receiving the results of the confirmatory testing, the patient will be called in to determine an appropriate plan of care.

☐ The patient acknowledges that the positive result was due to a non-prescribed or illicit substance.

☐ The patient acknowledges that the negative result was due to not having taken the prescription medication within the last 3 days.

☐ The patient acknowledges the POSITIVE NEGATIVE result due to:

_____

_____

3. As a result of my discussions with the patient, the following actions have been taken:

☐ The patient has been discharged from the practice for failure to comply with the Controlled Substance Agreement signed by the patient.

☐ The patient has been given a referral to an addiction medicine specialist. The patient has been advised that the patient's pain will continue to be treated with non-controlled substance medication until a recommendation has been received from the addiction medicine specialist.

☐ The patient has been counseled and advised that any future unexpected result will result in discharge from the practice.

☐ The patient's controlled substance prescription has been reduced until follow-up evaluation and discussion is completed during the next appointment.

☐ The patient will only receive non-controlled substance prescriptions for the treatment of his/her pain because he/she will not commit to using only the controlled substances that have been prescribed.

☐ The patient's controlled substance prescription was continued for _____ days to assist in the transition of care to another physician and to reduce the likelihood of withdrawal syndrome.

☐ The patient has decided to seek treatment for his/her pain with another physician.

I certify that I have discussed this form with the patient and have taken the actions noted above.

_____

[Physician name]