Employer/Carrier Request to Health Care Provider for Additional Information Regarding Recommendation for Substance Use Disorder Treatment

TO BE COMPLETED BY THE CARRIER/EMPLOYER

Patient Name: _____ Today's Date: _____

Patient ID #: _____ Date of Injury: _____

Employer: _____ Carrier: _____

Treating Provider: _____ IC File #: _____

TO RECOMMENDING HEALTH CARE PROVIDER:
You recently recommended the following treatment(s) for substance use disorder for the above-named employee:

_____

Your prompt completion and return of this form to the following person is appreciated:

Name: _____ Telephone number: _____

Fax number: _____ Email address: _____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Please provide the following additional information regarding the recommended treatment:

1. What are the clinical goals of the recommended treatment(s)? _____

_____

2. What measurable objective(s) is/are the treatment(s) expected to accomplish? _____

_____

3. Will treatment(s) require in-patient or out-patient rehabilitation: ☐ Inpatient ☐ Outpatient ☐ Both

4. What is the estimated length of treatment(s)?

   Number of weeks: _____

   Number of visits per week, if applicable: _____

   Intervals at which progress will be measured: _____

5. Will medication assisted treatment be used? ☐ Yes ☐ No

   If yes, name and dosage of the medication(s) to be used:

   NAME OF MEDICATION: DOSAGE:

   _____ _____

   _____ _____

   _____ _____

   Estimated length of medication assisted treatment, if known: _____

6. Please provide any other relevant information supporting the treatment recommendation: _____

_____

_____

_____

_____

Provider Signature _____

Printed Name_____ **Date** _____