

C914N

NURSE PRACTITIONER MEDICATION MANAGEMENT REPORT

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|-----------------------------|------------------------|----------------------------------|
| WORKER DETAILS | | WCB Claim Number |
| | | Personal Health Number |
| Surname | First Name and Initial | Date of Birth (yyyy/mm/dd) |
| Nurse Practitioner's Name | Telephone Number | WCB Practitioner Number |
| Date of Injury (yyyy/mm/dd) | Part of Body | Date of Examination (yyyy/mm/dd) |
| Diagnosis | | |

| | |
|---------------------|---------------------|
| Current complaints: | Objective findings: |
|---------------------|---------------------|

Current medications and dosages (including new prescriptions).

For what diagnosis are you prescribing opioids?

Are this patient's limitations due to opioid medication? Yes No Other If yes, explain.

Provide your own clinical estimate of your patient's level of function at this visit (check your numerical estimate).
0 = severe impact on function at home and work 10 = return to pre-injury functional level 0 1 2 3 4 5 6 7 8 9 10

Has there been overall improvement in the patient's **function** since opioids were first used?
 Yes, Describe improvement:
 No, opioid regimen will be adjusted (see below) No, opioid will be discontinued (see treatment below) No, other (see below)

If function is not improving, explain rationale for continuing opioid analgesics.

What is your treatment plan to improve the patient's function? (include further investigation / consultation).

Provide the patient's estimate of average pain severity in the last week (check the numerical estimate).
0 = no pain at all 10 = persistent severe pain Pain Scale 0 1 2 3 4 5 6 7 8 9 10

Has there been overall improvement in the patient's **pain** since opioids were first used?
 Yes No, opioid regimen will be adjusted (see Comments) No, opioid will be discontinued (see Comments) No, other (see Comments)
Comments:

Request for WCB resources (Mark with an "X": The WCB will contact you).
 Contact with WCB Case Manager Work Assessment Centre Referral Independent Medical Examination Contact with WCB Physician

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| Next follow up visit: (yyyy/mm/dd) | Nurse Practitioner's Signature | Date: (yyyy/mm/dd) |
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