

JSAS HEALTHCARE, INC.

PRESCRIPTION MONITORING PROGRAM REVIEW

Name: \_\_\_\_\_ Patient ID#: \_\_\_\_\_ DOB: \_\_\_\_\_

**Reason for PMP review:**

- Admission to long-term treatment (*greater than 30 days*)
- Earning first takehome
- Annual Nursing Assessment (*copy of PMP print out to Medical Chart, if any CDS over last year*)
- Pregnancy
- For cause

**Physician's Review:**

- PMP has been reviewed and no CDS issues were found.
- PMP has been reviewed and CDS prescriptions need further review by Medical Director and Treatment Team (*copy of PMP print out to Medical Chart*).

**Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

**If further review is needed, copies to Dr. Sue, Margo, Diane and Counselor.**

**If comments only, copy to counselor.**

**Original: Medical Chart**