KHS Pharmacy Dept.
Phone# 661-664-5101
Fax# 661-664-5191 Thank you!

ANALGESIC MEDICATION REQUEST

Kern Health Systems has received a treatment authorization request for additional pain medications for the following patient.

Patient Name:

Patient I.D. Number:
Medication Requested:
Submitted Diagnosis:

Please submit the following information to help us decide on the request for the above medication.

- ✓ **Kern Health Systems will limit the prescribing of this medication to one physician to avoid abuse by drug seeking patients.**

- ✓ **Please accurately describe the maximum number of doses per day the patient is allowed.**

  Maximum number of doses per day ______________

- ✓ **Is the need for the analgesic medication chronic or for a limited duration?**

  - ☐ **Chronic(Yes/No)** ______ How long will pt be on this med?
  - ☐ **Limited? (Yes/No)** __________ → **Duration** __________

- ✓ **Has this patient seen a pain specialist or are you going to refer the patient to a pain specialist?**

  Patient is seeing/ was seeing Pain Specialist (Dates) ____________________

  Patient will be referred to Pain Specialist (Yes/No) ________

- ✓ **Describe other treatments you have prescribed to reduce the patient's analgesic medication requirements.**
  * What formulary pain meds has pt tried??
  ____

* ____ * ______________
Physician **Date**

Return to Kern Health Systems

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Please answer all the above questions. MD needs to sign form. thx
KFHC