

NARCOTIC PRESCRIBER PLAN REFERRAL FORM

Patient Name: _____ ProviderName: _____

MaineCare ID #: _____ Provider ID#: _____

Provider DEA #: _____

Reason for referral:

- Concerned by and/or unaware of narcotic co-prescribers
- Desire for narcotic analgesia appears out of proportion to presenting symptoms and exam
- Frequent visits for various subjective complaints resulting in increased narcotics utilization
- Frequent lost, stolen, or destroyed prescriptions
- Frequent requests for early refills
- Other – please explain (i.e. altered prescriptions, failed Urine Drug Test, etc.)

- Have you discussed these issues with the patients? Yes No
- Do you consider yourself this person's primary care provider? Yes No
- Are you willing to be the designated narcotic prescriber? Yes No

Signature: _____

Date: _____

Please return to: Goold Health Systems
 P.O. Box 708
 Augusta, Maine 04332-0708
 Fax to: Goold Health Systems at 430-4646
 If you have any questions please call Goold Health Systems at:
 1-800-561-6707 or 207-622-1126 or TTY: 207-622-3210