Ohio Physicians Health Program

MEDICATION MANAGEMENT REPORT

Participant Name: _____

Months covered in this report:

☐ January	☐ February	☐ March	☐ April	☐ May	☐ June
☐ July	☐ August	☐ September	☐ October	☐ November	☐ December

The participant is compliant with taking their prescribed controlled medication: ☐ Yes ☐ No

1. Any changed in the dosage of controlled medication? ☐ Yes ☐ No
   If yes, what is the change?

2. Are there refills associated with this medication? ☐ Yes ☐ No
   If yes, how many?

3. Any new medication? ☐ Yes ☐ No
   If yes, what is the medication and dosage:

Please briefly explain ongoing medication plan:

Additional Comments:

Next Appointment:

Would you like OPHP to contact you regarding this individual? ☐ Yes ☐ No

Name (Please Print): _____

_____ _____

Signature Date