

Opioidspain Medications

Subject ID _____

Complete (or update) this form only after you have reviewed prescription information in the medical record and/or made contact with the appropriate pharmacy for this patient and this drug.

Patient not on drug between the 4 months prior to consent into REAL and today (please uncheck this if the patient starts taking this drug)

Patient not on this drug

Most recent prescription

Start at 4 months before the REAL consent date of [administrative_arm_1][p1f6q01_2].

Prescription #1

Name of opioids medication:

- Acetaminophen
- Acetaminophen & Codeine (Tylenol-Codeine #3 or #4)
- Acetaminophen & Oxycodone (Percocet, Endocet)
- Acetaminophen & Hydrocodone (Vicodin, Norco, Lortab)
- Amitriptyline/Elavil
- Buprenorphine/Belbuca/Butrans
- Buprenorphine film
- Buprenorphine & Naloxone film
- Celecoxib (Celebrex)
- Fentanyl (Duragesic)
- Gabapentin (Neurontin)
- Hydromorphone (Exalgo ER, Dilaudid)
- Ketorolac/Toradol
- Magnesium salicylic acid (Durasal)
- Meperidine (Demerol)
- Methadone (Dolophine)
- Morphine, short acting (Morphine Sulfate IR, MSIR)
- Morphine, long acting (MS Contin)
- Morphine, ultra long acting (Kadian)
- Morphine and Naltrexone (Embeda, MS IR)
- Morphine and Naloxone
- Oxycodone (Oxycontin, Roxicodone)
- Oxycodone, long acting (Oxycontin)
- Oxycodone, short acting (Roxicodone)
- Oxymorphone (Opana)
- Pentazocine/Talwin
- Pregabalin (Lyrica)
- Promethazine/Phenergan with Codeine
- Tapentadol/Nucynta
- Tramadol
- Venlafaxine/Effexor
- Medical marijuana/Cannabis
- Other pain medications (specify below)

If other: _____

Confirm these items in the medical record

Date prescription was written:

Is the prescription for pills or a liquid

- Pills
- Liquid

For pills that contain combinations of drugs, record the strength of each active ingredient. For non-combination drugs, use the first box to record the pill strength.

of pills prescribed _____

Narcotic drug strength Non-narcotic pain med strength Other drug in combo
 _____ mg _____ mg _____ mg

mls prescribed _____ ml
 Liquid strength

_____ mg
 per _____ ml solution

Confirm these items with the patient's pharmacy

Did not pick up initial prescription (do not check box for refills)

Date participant picked up prescription from pharmacy:

of pills filled:

of mls filled;

of days covered:

Prescription #2