Medical Recordkeeping [1]

Description: A description of what should be included in a buprenorphine patient's medical record.

Many portions of the medical record contain general information that is not specific to patients with substance use disorders or opioid dependence. An example of this is the history portion of the record.

The following sections of the medical record should be noted for all substance use patients:

- Initial diagnosis and treatment plan information
- History and physical examination
- Comparisons with initial presentation
- Assessment of pharmacological efficacy
- Lab tests and results
- Compliance with treatment plan
- Urine and blood drug screening
- Medications prescribed
- Dispensing of controlled substances

Treatment Plan

The treatment plan portion of the medical record should be a natural continuation of the previous portions of the medical record. The following information should be carefully documented and shared with the patient:

- Diagnoses and how determined
- Treatment goals
- Determination of medication to be used
- How medication will be used
- Psychosocial services required/recommended

When the practitioner reviews this information with the patient, he/she should include the patient in formulation of treatment goals. Following the patient-practitioner review, both parties should sign and date the information contained in the treatment plan. Information about buprenorphine -- such as its effects, what to expect, and what not to expect -- should be discussed with the patient, and this discussion should be documented as well. The practitioner must remember to put his or her DEA registration number on the patient's medical records, as well as the patient's prescriptions.

Links:
[1] http://www.buppractice.com/node/2655