Eaton Rapids Medical Center Family Practice + Redicare

Springport Medical Clinic
Eaton Rapids Medical Center

My Current Treatment Plan

My Medical Provider

My Behavioral Health Provider

My Medication Plan

Medication	Dose	Directions		Controlled Schedule:
	mg	# pills	# times/day	II, III, IV, V
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	mg	# pills	# times/day	II, III, IV, V

My Pharmacy for Filling Controlled Substances

Pharmacy Name:	Pharmacy City:	Pharmacy Telephone Number:

My Multidisciplinary Treatment Plan

	Physical Therapy		Hydrotherapy		Behavioral Health/CBT		Massage
	Progressive Restrengthening		Functional Restoration		TENS Unit		Manipulation Therapy
	Exercise/Weight Management		Side Effect Management/monitoring		Acupuncture		Other:

My Specialty Referrals

Specialty	Name of Specialist

Resources for Assistance with Addiction

I agree to the above treatment plan. I understand it is my responsibility to fully participate in all aspects of the plan. I understand a lack of full participation will result in my being tapered off any controlled medications and may result in my being dismissed from the practice at Eaton Rapids Medical Center Family Practice/Springport Medical Clinic.

Date: _____ Time: _____ Patient Signature: _____

Date: _____ Time: _____ Provider Signature: _____