

EXAMPLE

SUSPECTED DIVERSION REPORTING FORM FOR CONTROLLED SUBSTANCES CONTAINING OPIOIDS

Date of Report:	
Name of Hospice Care Provider:	
Address:	
Telephone:	Fax:
E-mail:	

Is this report the result of the hospice care patient or patient's family member's refusal to relinquish controlled substances containing opioids to the hospice care program upon the hospice patient's death or when no longer needed by the patient?

☐ YES ☐ NO

Name of Patient:
Address:
Name/s of individual(s) suspected of diversion:
Specific date or time period of suspected drug diversion:
Name and quantity of each missing or diverted drug:

Briefly describe the signs, events, or incident leading up to this report (attach additional information if necessary):

Name of staff member whom identified the suspected drug diversion:
Name of program staff member receiving the report of suspected drug diversion:
Name of supervisory staff member responsible for investigating the suspected drug diversion:

Date the suspected drug diversion was reported to local law enforcement agency:
Name of law enforcement agency the suspected drug diversion was reported to:

THIS FORM SHOULD BE RETAINED BY THE HOSPICE CARE PROGRAM FOR A PERIOD OF NO LESS THAN 4 YEARS FROM THE DATE OF REPORT

Reporting of suspected diversion is required by Section 3712.062 of the Ohio Revised Code