### SI 3: Deliverable B

**SI 3: Opioid Safety**

Due: Quarterly

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| **Number** | **Member Name** | | **Date of Birth** | **SFHP ID #** | | **Run Date of CURES Reviewed by Committee (must be within 1 month of review)** | | | **Date Reviewed** | | **Reason Reviewed** | | **Brief Recommendations** | |
| 1 |  | |  |  | |  | | |  | |  | |  | |
| 2 |  | |  |  | |  | | |  | |  | |  | |
| 3 |  | |  |  | |  | | |  | |  | |  | |
| 4 |  | |  |  | |  | | |  | |  | |  | |
| 5 |  | |  |  | |  | | |  | |  | |  | |
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| **Note: If patient is not covered by SFHP or HSF, then do not give name or ID # information in order to be HIPPA compliant. Also please** U**securely** U**email this list to PainManagement@sfhp.org. If unable to send secure email, send an email to that address to initiate secure email exchange.** | | | | | | | | | | | | | | | |