Opioid Risk Tool - Clinician Form

(including point values to score total)

	Mark each box that applies	
1. Family History of Substance Abuse:	**Female***	**Male**
Alcohol	☐ **1**	☐ **3**
Illegal Drugs	☐ **2**	☐ **3**
Prescription Drugs	☐ **4**	☐ **4**
2. Personal History of Substance Abuse:		
Alcohol	☐ **3**	☐ **3**
Illegal Drugs	☐ **4**	☐ **4**
Prescription Drugs	☐ **5**	☐ **5**
3. Age (mark box if between 16 and 45)	☐ **1**	☐ **1**
4. History of Preadolescent Sexual Abuse	☐ **3**	☐ **0**
5. Psychological Disease		
Attention Deficit Disorder, Obsessive-Compulsive Disorder, Bipolar, Schizophrenia	☐ **2**	☐ **2**
Depression	☐ **1**	☐ **1**

Scoring Totals:

Low Risk = 0 – 3 **Moderate Risk = 4 – 7** **High Risk = >7**

(Remove the scoring from the form if you plan to hand this out to the patient to complete!)

*Female / Male refers to the gender of the patient NOT the relative.

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EMR TEMPLATE FOR OPIOID RENEWAL

Diagnosis requiring opioids:
Duration of opioid use:
Screening tool risk level:
Narcotic contract on chart:
Last UDS date and results:

Analgesia
Activity
Aggravating factors
Affect
Abberant behavior
(or signs of dependence/see below)

Next refill due:
Script faxed?:
Pharmacy:

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screening questions for opioid dependence
3 or >of the following in a 12 month period

1-tolerance
-Need for increased dosed or diminished effect at same dose
2-Withdrawal
-withdrawal symptoms or alternate drugs taken to get rid of withdrawal symptoms
3-Substance taken in larger amounts and longer duration than intended
4-Persistent desire or unsuccessful attempt to cut down
5-A lot of time is spent on getting the substance, taking and recovering from its effects
6-Important social, recreational and occupational activities are given up due to substance use
7-Substance is taken despite knowing that it is causing or exacerbating physical or mental harm

Opioid Prescribing Agreement

This is an agreement between Dr. _____ and me regarding my pain medicines.

1. I will ONLY get my pain medicine from the doctor named above.
2. I will take my pain medicine as advised by the doctor.
3. I will tell my other doctor(s) that I am taking pain medicine from the doctor.
4. I will tell my doctor about ALL of my health problems.
5. I will tell the doctor about ALL of the medicines (over-the-counter, herbs, vitamins, those ordered by other doctors) I am taking.
6. I will allow the doctor to talk with other doctors about my health problems.
7. I will tell the doctor right away if I get pain medicine from any other doctor or emergency room.
8. I will keep my pain medicine locked in a safe place AND away from children.
9. I will bring all of my leftover pain medicine in their pharmacy bottles the every time I come to see the doctor.
10. The doctor or nurse may count the number of pills left in my bottle(s).
11. I will allow the doctor to check my urine (pee) or blood to see what drugs I am taking.
12. I will NOT share, sell, or trade my pain medicine with anyone.
13. I will NOT use someone else's pain medicine(s).
14. I will NOT ask the doctor for an early refill if I lose or misplace or run out of my pain medicine early.
15. I will NOT use illegal drugs (such as crystal meth, marijuana, cocaine) and I will not drink alcohol without the doctor's permission.
16. I know if I drive while taking pain medicine, I could be charged with driving under the influence (DUI) by the police. If I am charged with DUI while taking pain medicine, the doctor is not to blame.
17. I will only ask for refills during an office visit (Monday to Friday from 9:00 AM to 5:00 pm).
18. I will call the doctor's office at least 24 hours in advance if I need to cancel my appointment.
19. The doctor and my pharmacy may talk to the police if they think I am misusing or selling my pain medicine.
20. If I do not do all of the things listed above, the doctor may take me off of pain medicine.
21. If I do not do all of the things listed above, the doctor may send me to a drug treatment clinic.

_____	_____	_____
Patient Signature	Doctor Signature	Date

Opioid Prescribing Agreement

This agreement is being undertaken between _____,(the patient), and

Dr_____ (the doctor) regarding treatment of a chronic pain problem using long-term opioid therapy.

1. The patient hereby agrees that this treatment has been explained to him/her in terms of the purpose, the side effects of the medication and the risks involved. During dosage adjustments (titration) drowsiness can be a temporary side effect. During these times the patient agrees not to drive a vehicle or perform other tasks that could involve danger to self or others. The doctor will advise the patient when these activities are safe to perform again.

2. The patient understands that using long-term opioids to treat chronic pain may result in the development of a physical dependence on this medication, and that sudden decreases or discontinuation of the medication will lead to the symptoms of opioid withdrawal. The patient understands that opioid withdrawal is uncomfortable but not life threatening. Physical dependence by itself does not mean the same thing as addiction to opioids.

3. The patient agrees not to change the dose or the frequency of taking their medication without first consulting the doctor, and also agrees to follow-up with the doctor, as required by the doctor, for monitoring of this treatment.

4. The patient agrees to keep the prescribed medication in a safe and secure place. Lost, damaged or stolen medication will not usually be replaced until the next regularly scheduled office visit.

5. The patient agrees not to give, sell, lend or in any way provide his/her medication to any other person, and agrees to obtain all of his/her medication from only one licensed pharmacist. The patient consents to open communication between the pharmacist and the doctor on any matter related to the patient's medications.

6. The patient agrees not to seek, obtain, or use **ANY** mood-modifying medication, especially pain medication, sleeping pills or tranquilizers, from **ANY** other physician, without first discussing this with the doctor. The patient gives the doctor consent to provide a copy of this document to any other physicians, Emergency Departments or walk-in clinics.

7. In patients taking long-term opioid therapy, there is a small but definite risk that opioid addiction can occur. Almost always, this occurs in patients with a current or past history of other drug or alcohol abuse. Therefore, the patient agrees to refrain from the use of **ALL** other mood modifying drugs, including alcohol, unless agreed to by the doctor. The moderate use of nicotine and caffeine are an exception to this restriction. The patient agrees to submit to timely, random urine, blood, saliva or hair testing, at the doctor's request, to verify compliance with this. At any time during treatment, the patient agrees to be assessed by an addiction specialist if requested by the doctor.

8. The patient understands that one of the main measures of successful treatment is significant improvement in the patient's function. The patient agrees to open communication between the doctor and those close to the patient, such as family members, to help determine function and adverse effects due to treatment.

9. The patient agrees to attend and participate fully in any other reasonable assessments or pain treatment programs which the doctor may recommend at any time.

The patient understands that **ANY** deviation from the above agreement may be grounds for the doctor to discontinue opioid therapy at any time and prescribe other treatments instead.

Signed at _____ on _____, 200

_____ _____

(patient) *(doctor)*

Patient Contract for Chronic Narcotic Therapy

I understand that this agreement between me, _____, and Dr. _____is intended to clarify the manner in which chronic (long-term) narcotics will be used to manage my chronic pain. Chronic narcotic therapy for patients who do not suffer from cancer pain is a controversial issue. I understand that there are side effects to this therapy; these include, but are not limited to, allergic reactions, depression, sedation, decreased mental ability, itching, difficulty in urinating, nausea, and vomiting. Care should be taken when operating machinery or driving a car while taking these medications. When narcotics are used long-term, some particular concerns include the development of physical dependence and addiction. I understand these risks.

I understand that my family physician will prescribe narcotics only if the following rules are followed:

All narcotic prescriptions must be obtained from St Joseph's Family Medical Centre. If a new condition develops, such as trauma or surgery, then the physician caring for that problem may prescribe narcotics for the increase in pain that may be expected. I will notify my family doctor within 48 hours of my receiving a narcotic or any other controlled substance from any other provider. For females only: if I am becoming pregnant while taking this medication, I will immediately inform my obstetrician and obtain counseling on risks to the baby.

All requests for refills must be made by contacting my family doctor's office during business hours, and at least three workdays in advance of the anticipated need for the refill. All prescriptions must be filled at the same pharmacy: _____ I authorize my pharmacy to release a record of my medications to this office upon request. A copy of this contract will be sent to my pharmacy.

The daily dose may **not** be changed without my family physician's consent. This includes either increasing or decreasing the daily dose.

Prescription refills will **not** be given prior to the planned refill date determined by the dose and quantity prescribed. I will accept generic medications.

Accidental destruction, thief or loss of medications or prescriptions will **not** be a reason to refill medications or rewrite prescriptions early. I will safeguard my narcotic medications from use by family members, children or other unauthorized persons.

It is our policy that all appointments must be kept or cancelled at least two working days in advance. The original bottle of each prescribed narcotic medication must be brought to every visit.

Grounds for dismissal from Dr _____'s care are: evidence of recreational drug use, of drug diversion, of altering scripts (this may result in criminal prosecution), of obtaining narcotic drugs from other doctors without notifying this office; abusive language toward our staff.

This treatment contract may be discontinued if I do not meet the conditions described above, or if there is the development of progressive tolerance, if alcohol or other intoxicants are used, if unmanageable side effects emerge, if the use of narcotics results in diminishing functioning or poor pain control, or if there is engagement in any criminal activities.

_____ _____

Patient's signature date

_____ _____

Witness' signature date