Opioid Assessment Service

initial patient evaluation form

Date: referring physician: PCP (if not referring):

Last name: first: MI: age: DOB: sex: M F

Referring physician concerns:

Pain History

PAIN DX: Onset of pain:

Evaluation/management to date (imaging, consultants, interventions, etc.):

ANALGESIA GOAL from chronic opioid therapy agreement: _____

FUNCTIONAL GOAL from chronic opioid therapy agreement: _____

Current Analgesic Regimen

Drug name	Dose	Frequency	routine or prn?	How long at this dose?
1.				
2.				
3.				
4.				
5.				

Narrative comments:

Current Morphine Daily Equivalent [utilize MDE calculator: http://agencymeddirectors.wa.gov/mobile.html } mg

Analgesia: [scale of 0-10 where zero = no pain, 10 = pain as bad as possible]

1. What is patient's pain level at current time?

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as possible

2. What is patient's pain level on average during the past week?

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as possible

3. What is patient's worst pain level during past week?

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as possible

4. What percent of patient's pain does he/she feel has been relieved by his/her medicine during the past week? _____%

5. Does patient feel he/she has been getting enough relief from his/her medicine to make a difference in their life? Y N

6. (To clinician): Is the patient's pain relief clinically significant? Y N Unsure

Function/Activities of Daily Living

1. Able to work? Y N (if no, for how long? _____ on SSDI? Y N

Over last month:	Better	Same	Worse	*comments*
2. Physical functioning	☐	☐	☐	
3. Family Relationships	☐	☐	☐	
4. Social Relationships	☐	☐	☐	
5. Mood	☐	☐	☐	
6. Sleep	☐	☐	☐	
7. Ability to concentrate	☐	☐	☐	
7. Overall Functioning	☐	☐	☐	

Adverse Events

Any side effects from current opioid regimen? Y N

	None	Mild	Moderate	Severe	Comments
Nausea?	☐	☐	☐	☐	
Vomiting?	☐	☐	☐	☐	
Constipation?	☐	☐	☐	☐	
Itching?	☐	☐	☐	☐	
Mental cloudiness?	☐	☐	☐	☐	
Sweating?	☐	☐	☐	☐	
Fatigue?	☐	☐	☐	☐	
Drowsiness?	☐	☐	☐	☐	
Respiratory?	☐	☐	☐	☐	
Other?_____	☐	☐	☐	☐	
Other? _____	☐	☐	☐	☐	

PMH

Psychiatric diagnosis(es) (PTSD, depression, anxiety, substance abuse disorder, overdose, etc.)?

Neurologic (admissions for delirium, mental status change, etc.)?

GI (ED/Admits for obstipation, stool noted on abd imaging, etc.)?

Pulmonary (PNA –specifically RLL suggestive of aspiration, intubation for respiratory insufficiency, etc.)?

Sleep-disordered breathing?

Orthopedic (falls/trauma/fractures)?

Family history

Substance use disorders?

Psychiatric (Substance use disorders, suicides, etc)?

Social History - given sensitive nature of this part of medical history, it is helpful to preface them with a statement to prepare the patient regarding subsequent quesioning. For example*, "The next questions I am going to ask you may find uncomfortable. If you do not want to answer them that is OK, but medical studies show the answers can be helpful in figuring out how best to deal with your pain and medications."*

Relationships (assess current level of social support):

Smoker?

ETOH use? (If yes, ever DUI? Relationship problems related to your drinking?)

Illicit drug use?

History of childhood neglect or abuse?

Current stressors identified (social, financial)?

Opioid-related Aberrant Behaviors

- ☐ Purposeful oversedation
- ☐ Negative mood change
- ☐ Intoxication
- ☐ Increasingly unkempt or impaired
- ☐ Involvement in car or other accident
- ☐ Request for early renewals
- ☐ Increased dose without authorization
- ☐ Insistence on certain meds by name
- ☐ Abuse of alcohol or illicit drugs
- ☐ Attempts to obtain meds from other physicians
- ☐ Change route of administration
- ☐ Use of pain meds in response to situation stress
- ☐ Report of lost or stolen meds
- ☐ Contact with street drug culture
- ☐ Hoarding (ie: stockpiling) of medication
- ☐ Arrested by police
- ☐ Victim of abuse
- ☐ Other: _____

EXAM

Labs/Studies

Prior CURES report done/available? Y N if yes, results: _____

Prior urine tox screen9s) done? Y N (if yes, results: _____

ABD imaging showing retained stool? Y N (if yes, study _____ date: ___/___/___)

Assessment

(To clinician): Patients overall severity of side effects? None Mild Moderate Severe

Is your overall impression that this patient is benefiting from opioid therapy? Y N Unsure

comments: _____

_____

Additional testing pending OAB review:

☐ ***CURES report*** ☐ ***Utox*** ☐ ***serum testosterone*** ☐ ***KUB*** ☐ ***12 lead EKG***
☐ ***other;_____***

_____ ___/___/___

clinician signature *date*

<u>Opioid Assessment Board Consensus</u> date review: ___/___/___

☐ **Ineffective dose –**

Inadequate titration

Disease progression

☐ **Excessive Side Effects**

☐ **Ineffective analgesia**

Opioid resistant pain

Tolerance

Hyperalgesia

Opioid-induced toxicity

☐ **Aberrant opioid related behavior**

Addiction related

Non-addiction related

☐ **Other: _____**

OPIOID FAILURE? (Defined as >120mg MDE, >3 mo duration, with persistent pain scores >5/10, and/or failure to achieve functional goals, +/- significant adverse drug effects). ☐ **YES** ☐ NO

RECOMMENDATION(s):

☐ PCP reassurance/guidance/advice: _____

☐ Subspecialist referral: _____ reason:_____

☐ Opioid discontinuation +/- medication symptom management

☐ Opioid weaning clinic

☐ Referral to Addiction Services

☐ Other:_____