Chronic Opioid Therapy Worksheet: A Companion to Chronic Pain Treatment

Use this worksheet to aid in documentation of treatment and management for your patients receiving chronic opioid therapy.

Initial Visit

The following questions should be answered and practices completed and discussed with patients (and their caregivers) when a trial of opioid therapy, as a component of chronic pain management, is being considered as a potential treatment.

- **Pain assessment**
  - Has adequate evaluation (work-up) been done to establish a pain diagnosis? If not, what needs to be done PRIOR to prescribing opioid treatment?
  - Based on this diagnosis, have other non-opioid pain treatments been tried and determined to be insufficient to attain adequate pain relief and functional improvements for this particular patient?
  - Have medical, behavioral, and social risks of opioid therapy been adequately assessed and a favorable benefit-to-risk ratio determined?
  - What is the risk score (using a standard, validated tool, such as the Opioid Risk Tool [ORT] or the Screener and Opioid Assessment for Patients with Pain [SOAPP®])?
  - Based on this level of risk (low, medium, high), can you manage this patient alone or with co-management from another healthcare professional? Or, is referral for management to a healthcare professional with expertise in addiction, mental health, or other relevant areas indicated?

- **Specific, measureable/monitorable goals of therapy (eg, restore function to perform a particular activity, reduce pain to a targeted level, improve sleep, other personal goal[s])**

- **Informed Consent**
  - Potential adverse effects of opioids including but not limited to sleepiness, constipation, nausea, itching, hypogonadism, respiratory depression, inadequate pain relief, risk of addiction, drug interactions, and pregnancy-related concerns in at-risk women
  - Definitions and descriptions of tolerance, physical dependence, and addiction
  - Alternative pain treatments
  - Discussion of driving and work safety

- **Opioid Treatment Agreement**
  - *Widely used, but not evidence based*
  - Schedule for office visits and prescription renewal policies
  - Monitoring processes (eg, pill counts, random urine drug tests, etc)
  - Safe use of opioid therapy (ie, use only as directed, storage and disposal of opioids)
  - Prohibited behaviors as grounds for tapering or discontinuation of opioid therapy
  - Obtaining opioids from one prescriber and filling prescriptions at one pharmacy
    - Medication guides should be provided or patients should be reminded to review medication guides upon receipt of prescriptions at the pharmacy
  - Reasons and methods for discontinuation of opioid therapy (“Exit Strategy”)

- **Nonpharmacologic and multidisciplinary therapies that can or should be integrated into the overall pain treatment plan (eg, physical therapy and/or exercise, TENS, cognitive/behavioral therapy, acupuncture, pacing)**

- **Pain documentation tools (eg, pain diary, the American Pain Foundation’s Targeting Chronic Pain: Your Personal Notebook) to use between this visit and next to record pain and treatment outcomes**

Reassessment Visit(s)

Discuss the following with patients (and their caregivers) at visits after opioid therapy has been prescribed.

- What is the pain intensity level?
- Have the trends for pain at rest, with routine activity, and at the present time, changed?
- Is the primary pain location the same?
- Have the key pain descriptors been modified?
- Is there improvement in the ability to perform activities of daily living and other pre-defined goals?
- Was the medication guide for the prescribed therapy reviewed?
- Are there any concerns regarding the treatment plan?
- Have any adverse events been reported (e.g., excessive sedation, bowel or bladder dysfunction, cognitive changes, changes in breathing during sleep [per sleep partner])?
- Is there evidence that the treatment plan is being followed and medications are being used exactly as prescribed?
- Were any adjustments to the treatment plan required prior to this visit?
- Were you notified of these changes either by your patient, their caregiver, or your office staff?
- Have you considered querying your state’s prescription monitoring program, if available, or performing a urine drug screen/test?

- Based on the answers to these questions, and your clinical judgment, make the decision to:
  - Continue the patient on the current regimen
  - Change the regimen
  - Discontinue the regimen and document the reasons for discontinuation
  - Refer for second opinion or additional specialty opinion(s)

- Document and discuss next steps in the treatment plan with the patient and caregiver

Notes

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