STANDING ORDER FOR PAIN MANAGEMENT (OPIATE MEDICATIONS)

POLICY:

Under this standing order medical assistants and RNs with proper training may support the care of patients who use opiates for chronic pain.

PURPOSE:

Chronic pain leads to physiological issues other than physical discomfort. Cure of chronic pain is rarely achieved, but much can be done to reduce suffering and improve quality of life [1]. Long-term use of opiate medications has certain risks; clinics with standardized approaches and protocols can decrease the risk of abuse and harm, and ensure a better experience for patients and staff.

PROCEDURE:

INITIAL VISIT

1. Medical assistant role for new patients:
   a. Ask patients for records from previous prescriber. If the patient does not have them, give the patient a form to fill out (record release) to ensure records are obtained. Inform patient it is their responsibility to obtain records.
   b. Collect basic information and document in progress note:
      i. Name and contact information for previous prescriber of opiate medications, date of last prescription, and pharmacy
      ii. Current complete medication list with doses
      iii. What treatments have been used for pain (include physical therapy, specialists, alternative medicine providers)
      iv. Other medical problems/diagnoses
   c. Ask patient to leave a urine sample (explain that it is a routine procedure for all patients who receive opiate medications).
   d. Give patient a copy of the pain management agreement/informed consent to review and sign.
   e. Ask provider if they would like you to call pharmacy to confirm date, amount, and prescriber for recent opiate medications.

2. Medical assistant role for existing patients on follow-up visits:
   a. Ask all patients to leave a urine sample before seeing the provider.
      a. Rationale: decreases the possibility of patients stating “I just used the restroom” and not being able to collect a urine drug screen.
      b. Decreases the feel of a urine drug screen being punitive (since leaving urine is part of every routine visit).
      c. If >12 months since last urine drug screen, MA should fill out the lab order

and send the sample.

d. If <12 months since last urine drug screen, MA should ask provider if the urine should be sent, or discarded.

b. Document current medication list and dose.

c. Confirm pain management agreement is in the chart and signed within last 12 months.

   a. If not there, or outdated, give pain management agreement to patient to review and sign.
   d. If directed by provider, perform a pill count (document in the progress note the date filled on the bottle of medications supplied by the patient, the name of the prescription, dose, and number of tablets in the pill bottle).

Medical Director

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Printed Name

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Signature

Effective date

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Date reviewed

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Date revised

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