Prescribing Controlled Substances for Pain: Basic Documentation

Patient Evaluation and Risk Stratification:

- Medical history and physical examination
- Psychological evaluation: PHQ9, Opioid risk tool, DIRE
- Medical diagnosis and medical necessity discussion
- Explore non-opioid therapeutic options

Patient Consent:

- Risks and benefit discussion
- Counselling on safe ways to store and dispose of medications
- Potential side effects: nausea, constipation, sexual dysfunction, hypogonadism, osteoporosis
- Drug interactions and over-sedation
- Opioid misuse, dependence, addiction, overdose

Pain Management Agreement:

- Recommended if over 3 months of opioids
- Agreement to only one physician and only one pharmacy
- Agreement to periodic drug testing
- Policy on early refills and lost prescriptions
- Patient responsibility for safe use (alcohol, other substances, storage and disposal)
- Specific reasons when drug therapy may be changed or discontinued

Ongoing Patient Assessment:

- Suggested minimum of every 6 months face to face visit
- Documentation of progress towards functional goals
- Documentation of absence of adverse events, overdose or suspicion of diversion

Compliance Monitoring:

- CURES/PDMP report
- Drug testing at least twice a year

Medical Records:

- History and physical examination, evaluations and consultations
- Patient consent
- Pain management agreement
- Risk assessment screening tools used
- Treatments and medication prescribed
- Document progress towards pain management and functional improvement
- Document CURES/PDMP data searches and any discrepancies if found
- Document all orders for opioids whether written, telephoned or electronic