Evaluación inicial para terapia crónica con opiáceos

Estamos dedicados a colaborar con usted para desarrollar un plan integral de manejo del dolor. Sus respuestas a estas preguntas nos ayudarán a controlar su dolor de forma más segura. El Estado de Washington exige que controlemos a los pacientes que toman opiáceos después de 90 días por una afección dolorosa. Los pacientes cubiertos por el seguro de indemnización de trabajo y que toman opiáceos durante 4 semanas tendrán que llenar lo siguiente según la recomendación de Trabajo e Industrias actualizada en julio de 2013.
Las siguientes preguntas se han estudiado y usado en muchos establecimientos de salud para evaluar cómo los pacientes podrían responder a los analgésicos. Algunas preguntas pueden ser temas confidenciales; sin embargo, es importante que los pidamos.

1. ¿Ha visitado usted a un especialista en dolor en el pasado o lo está visitando actualmente?
   a. Si es así, nombre del proveedor: ______________________________
   b. ¿Planea usted seguir haciendo que su especialista en dolor controle sus medicamentos contra el dolor? Si es así, DETÉNGASE AQUÍ. No tiene que responder las preguntas restantes.
2. ¿Tiene usted antecedentes de la familia inmediata de abuso de sustancias de: (marque todo lo que corresponda)
   a. Alcohol? ☐
   b. Drogas ilegales? ☐
   c. Medicamentos de receta? ☐
   d. Ninguno de los anteriores ☐
3. ¿Tiene usted antecedentes de abuso de sustancias de: (marque todo lo que corresponda)
   a. Alcohol? ☐
   b. Drogas ilegales? ☐
   c. Medicamentos de receta? ☐
   d. Ninguno de los anteriores ☐
4. ¿Está usted entre los 16 y los 45 años de edad? Sí No
5. ¿Antecedentes de abuso sexual como preadolescente? Sí No
6. ¿Tiene usted alguno de los siguientes?
   a. Trastorno de déficit de atención, trastorno obsesivo compulsivo, bipolar, esquizofrenia Sí No
   b. Depresión Sí No

Por favor responda las siguientes dos preguntas acerca de *su dolor actual:*

7. Durante el último mes, **en promedio**, ¿cómo calificaría su dolor?
   (Sin dolor) 0 1 2 3 4 5 6 7 8 9 10 (no puede haber peor dolor)
8. Durante el último mes, ¿cuánto interfirió su dolor con sus actividades diarias?

0)	Ninguna interferencia. Va a trabajar todos los días, tiene una vida social fuera del trabajo, toma parte activa en la vida familiar.
1)	Puede trabajar/ofrecerse como voluntario, está activo ocho horas al día, toma parte en la vida familiar, tiene actividades sociales limitadas fuera.
2)	Puede trabajar/ofrecerse como voluntario durante al menos seis horas al día, tiene energía para hacer planes para una actividad social por la noche durante la semana, está activo los fines de semana.
3)	Puede trabajar/ofrecerse como voluntario durante unas horas al día, está activo al menos cinco horas al día, realiza actividades simples los fines de semana.
4)	Puede trabajar/ofrecerse como voluntario en horas limitadas, tiene actividades sociales limitadas el fin de semana.
5)	No puede trabajar/ofrecerse como voluntario, tiene dificultades con las responsabilidades de casa y las actividades fuera de casa.
6)	Realiza tareas simples en casa, tiene actividades mínimas fuera dos días a la semana.
7)	Se viste en la mañana, tiene actividades mínimas en casa, tiene contacto con amigos por teléfono o correo electrónico.
8)	Se levanta de cama pero no se viste, permanece en casa todo el día.
9)	Permanece en cama al menos medio día, no tiene contacto con el mundo externo.
10)	No puede realizar ninguna actividad. Permanece en cama todo el día, se siente impotente y sin esperanza en la vida.

Apnea del sueño:

1. ¿Se le ha diagnosticado con apnea del sueño? Sí No
2. ¿Ronca ruidosamente? Sí No
3. ¿Ha sido alguien testigo de que usted deja de respirar durante el sueño? Sí No

Chronic Opioid Therapy Initial Assessment

We are committed to partnering with you to develop a comprehensive pain management plan. Your responses to these questions will aid us in managing your pain more safely. WA State requires that we monitor patients taking opioids after 90 days for a painful condition. Patients covered by workers compensation insurance and taking opioids over 4 weeks will need to complete the following per L&I's July 2013 updated guideline.
The questions below have been studied and used in many healthcare settings to assess how patients may respond to pain medications. Some questions may be sensitive topics however they are important for us to ask.

1. Have you seen a pain specialist in the past or are currently being seen?
   a. If yes, name of Provider: ______________________________
   b. Do you plan to continue to have your pain specialist manage your pain medications? If so, STOP HERE. No need to answer the remainder of these questions.
2. Do you have an immediate family history of substance abuse of: (mark all that apply)
   a. Alcohol ☐
   b. Illegal drugs ☐
   c. Prescription drugs ☐
   d. None of the above ☐
3. Do you have a history of substance abuse of: (mark all that apply)
   a. Alcohol ☐
   b. Illegal drugs ☐
   c. Prescription drugs ☐
   d. None of the above ☐
4. Are you between the age of 16 and 45? Yes No
5. History of preadolescent sexual abuse? Yes No
6. Do you have any of the following:
   a. Attention deficit disorder, obsessive compulsive disorder, bipolar, schizophrenia Yes No
   b. Depression Yes No

Please answer the following two questions about *your current pain*:

7. In the past month, **on average**, how would you rate your pain?
   (No pain) 0 1 2 3 4 5 6 7 8 9 10 (pain as bad as could be)
8. In the past month, how much has your pain interfered with your daily activities?

0)	No interference. Goes to work each day, has a social life outside of work, takes an active part in family life.
1)	Can work/volunteer, be active eight hours daily, takes part in family life, has limited outside social activities.
2)	Can work/volunteer for at least six hours daily, has energy to make plans for one evening social activity during the week, is active on the weekends.
3)	Can work/volunteer for a few hours daily, is active at least five hours daily, does simple activities on the weekends.
4)	Can work/volunteer limited hours, has limited social activities on weekend.
5)	Not able to work/volunteer, struggles with home responsibilities and outside activities.
6)	Does simple chores around home, has minimal outside activities two days a week.
7)	Gets dressed in the morning, has minimal activities at home, has contact with friends via phone or email.
8)	Gets out of bed but doesn't get dressed, stays at home all day.
9)	Stays in bed at least half the day, has no contact with the outside world.
10)	Unable to carry out any activities. Stays in bed all day, feels helpless and hopeless about life.

Sleep apnea:

1. Have you been diagnosed with sleep apnea? Yes No
2. Do you snore loudly? Yes No
3. Has anyone ever witnessed you stopping breathing during sleep? Yes No

Title of Org

Patient Label

Chronic Controlled Substance Agreement

This agreement clarifies the provider and patient responsibilities when controlled substances are prescribed. Your provider intends to manage your condition in a way that is both effective and safe for you, your community/family and, in compliance with the law. **For your safety, your provider is likely to stop prescribing any controlled substance medication(s) for you if you fail to follow this agreement and a drug-dependence program may be recommended.**

This agreement is with your prescribing provider: ______________________________ print name/Department	**Your Initials**
I AGREE to take all Chronic Controlled medications only as prescribed and only my own medications from the above provider or designated alternate in his/her absence.	
I WILL not seek controlled substances from other clinics or Emergency Rooms except in the case of an emergency. I will tell my other providers that I am taking controlled substance medications and will be responsible to inform my above provider of any additional medications that might have been prescribed.	
I AGREE to get all my controlled substances from this pharmacy______________________________	
I AGREE to arrange for refills only during regular office hours 8:00 a.m.to 4:30 p.m., with 72 hours' notice. Controlled substances will not be refilled after hours, on weekends or on holidays.	
I AGREE to secure and store my meds in a secure location, safe from children or others. Lost, stolen or damaged opioid medications/prescriptions will not be replaced. Benzodiazepine replacement will be assessed on an individual basis. Early or extra refills of controlled substances will not be provided.	
I AGREE to never sell, give away or share my medications with anyone, use the medications of others or take street (illicit or illegal) drugs.	
I UNDERSTAND that there are additional risks of taking my medications with alcohol and /or marijuana	
I AGREE to attend appointments, tests or treatments as recommended by my above provider to improve my daily function.	
I AGREE to give random urine, blood sample and/or pill counts as directed by the above provider and will be responsible for the costs of the drug testing regardless of insurance coverage.	
I UNDERSTAND my provider will review pharmacy or prescription databases and communicate with pharmacists or health care providers to coordinate my care.	
I UNDERSTAND there are many risks associated with controlled medications including addiction, tolerance, sedation, death from an overdose, withdrawals if suddenly stopping the meds or even seizures and death if suddenly stopping benzodiazepines.	
(Males only) I am aware that chronic opioid use has been associated with low testosterone levels. This may affect my mood, stamina, sexual desire, physical and sexual performance.	
(Females only) If I am of childbearing age, **I certify** that I am not pregnant and will use appropriate contraceptive measures during the course of treatment with controlled substances. **I understand** that if I become pregnant while taking these medications that I should immediately notify my providers. Should I use opioids or benzodiazepines during my pregnancy; the baby will be physically dependent on these meds after birth. Benzodiazepines can cause increased harm to the fetus. Withdrawal from these meds can be life threatening for the baby	
I UNDERSTAND that my prescribing provider will continue to evaluate the possible benefit versus the side effects or problems the medication(s) may be causing me. If at any time the prescribing provider determines the risks to my health or the side effects of the medication(s) outweigh the benefits, **I understand** the prescribing provider may taper and/or stop prescribing controlled substances for me, even if I have followed the Treatment Agreement, and even if I am not in agreement with the provider.	

I have had an opportunity to have any questions answered to my satisfaction, have received a copy of this agreement and the outline of safety and disposal risks due to these medications.

Patient Signature: ____ **Date:__/__/___**

Provider Signature: ____ **Date:__/__/___**