Chronic Pain Flow Sheet
FOR THE EVALUATION AND TREATMENT OF CHRONIC NON-CANCER PAIN

ASSESSMENT
- Evaluate the original tissue injury and determine nociceptive, neuropathic, or central characteristics of the pain perception.
- Assess the risk of prescribing opioids to a patient through assessment tools: ACE, pain catastrophizing scale, PHQ-15, STOP-BANG, functional (e.g. Oswestry) or abuse (e.g. ORT) assessments, and trauma/PTSD screening.
- Obtain and review prior records, or for an established patient, re-familiarize yourself with your patient’s past history and evaluations.
- A UDS and query of the PDMP prior to assuming prescribing and periodically thereafter, but no less than yearly.

NON-OPIOID OPTIONS
- Exercise, restorative sleep, and behavioral supports should be a major component to any pain-management program.
- A team approach to care is essential to achieve functional improvement and improved quality of life.

ONGOING MONITORING
- Monitor all patients on chronic opioids.
- Every visit:
  - Evaluate progress toward functional goals. Strongly consider weaning in the absence of functional improvement on opioids.
  - Screen for appropriate medication use.
- Periodic assessment (no less than annually):
  - Urine drug screening
  - Pill counts
  - Callbacks
  - PDMP query

OPIOID TREATMENT
- Rarely prescribe opioids on the first visit.
- Discuss the risks vs. benefit of opioids and get a signed material risk notice.
- Create a care plan that includes functional goals.
- Discuss and plan for dose reduction (see tapering section in the OPG guidelines).
- Co-prescribe naloxone rescue kit to a loved one or family member.

STOP AND REASSESS
- Benzodiazepines should not be taken at the same time as opioids.
- Methadone should be used rarely, and if so, in low doses (< 30 mg/d).
- Respiratory disease (COPD, sleep apnea, etc.) narrows the window of safety with opioids.
- Evidence of substance abuse, past or present.
- Illegal activities regarding medication or illicit drugs.
- Lack of functional improvement.