OPMPP Initial Patient Consult Worksheet

ONTARIO PHARMACISTS ASSOCIATION
Advocating Excellence in Practice and Care

Date			
Location of Consult	☐ In-person at the pharmacy	☐ Virtual	☐ Other:

Patient		
Last Name		**First Name**
Address		
DOB	**Gender:** ☐ Male ☐ Female ☐ Self-identify	**Phone**
Consent obtained from: ☐ Patient ☐ Agent: (name, relationship to patient)		

Primary Care Provider	
Name	
Designation	
Phone	**Fax**

Medical History

☐ Existing pain diagnoses
☐ Other medical conditions
☐ Allergies/intolerances and reaction

Medications (from all sources; or attach list)

☐ Prescription medications
☐ Non-prescription medications
☐ Natural health products
☐ Medical cannabis

Medication & Strength	Route	Directions	Indication	General comments (i.e., efficacy, side effects, adherence)

☐ Daily Total Dose [(morphine milligram equivalents (MME)] Calculation:

Assessment *(Note: based on professional judgment, referral to another healthcare provider may be required.)*

Routine Opioid Outcomes Monitoring (ROOM) Tool[1]
(Used with permission from Dr. Suzanne Nielson of Monash Addiction Research Centre and Dr. Laura Murphy of University Health Network)

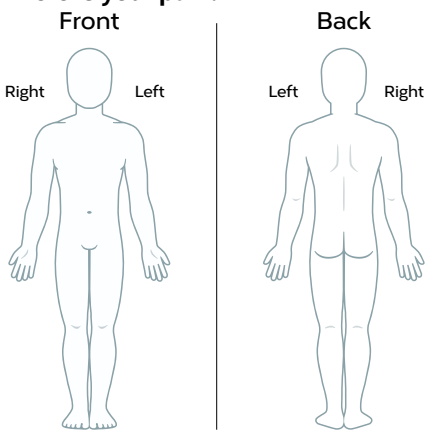
1. Have you been using an opioid for longer than 3 months?

☐ Yes ☐ No (Do not administer this tool)

2. How long have you used opioids?

☐ **Months**
☐ **Years**

3. Where is your pain?



What types of pain do you have? (check all that apply)

☐ Acute (in addition to chronic)
☐ Headache
☐ Muscle/joint/bone pain (Musculoskeletal)
☐ Nerve (Neuropathic)
☐ Fibromyalgia
☐ Post-surgical/post-trauma
☐ Other
☐ Unknown

4. What number best describes your pain on <u>average</u> over the past 7 days?

No Pain — Mild or well managed pain: 1 2 3 4 — Moderate pain: 5 6 — Severe or unmanaged pain: 7 8 9 10 — **Pain as bad as you can imagine**

5. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

Does not interfere 1 2 3 4 5 6 7 8 9 10 **Completely interferes**

6. What number best describes how, during the past week, pain has interfered with your general activity?

Does not interfere 1 2 3 4 5 6 7 8 9 10 **Completely interferes**

Please indicate how often you have been bothered by the following problems over the past three months. There are no right or wrong answers.

Not at all (0) — A little (1) — Quite a lot (1) — A great deal (1)

7. In the past three months, did you use your opioid medicines for other purposes, for example, to help you sleep or to help with stress or worry?

8. In the past three months did opioid medicines cause you to feel slowed down, sluggish or sedated?

9. In the past three months did opioid medicines cause you to lose interest in your usual activities?

10. In the past three months did you worry about your use of opioid medicines?

A total score of **3 or more** over the four items indicates the patient is likely to meet criteria for opioid use disorder. Further assessment is warranted.

TOTAL

Routine Opioid Outcomes Monitoring (ROOM) Tool (cont.)

Please indicate how often you have been bothered by the following problems over the last two weeks. There are no right or wrong answers.

Not at all	Several Days	More than half days	Nearly everyday
0	1	2	3

11. Little interest in doing things ____

12. Feeling down, depressed or hopeless ____

A total score of 3 or more indicates that the patient could be experiencing depression and/or anxiety. Further assessment is warranted.

TOTAL ____

13. How many times in the past year have you had 4 (for women) or 5 (for men) or more drinks in a day?
(a response of 1 or greater is considered positive for risky drinking) ____

14a. Are you experiencing constipation?
If symptoms are current, speak to healthcare professional. ☐ Yes ☐ No

14b. If yes: Are you taking any of the following medication or supplements for constipation? (prescribed or OTC)

- ☐ fibre supplement
- ☐ glycerin
- ☐ lactulose
- ☐ magnesium citrate
- ☐ magnesium hydroxide
- ☐ magnesium sulfate
- ☐ polyethylene glycol (PEG)
- ☐ sodium phosphate enema
- ☐ bisacodyl
- ☐ senna
- ☐ docusate sodium/calcium
- ☐ naloxegol
- ☐ unsure
- ☐ other

Substance Use[2]

Review history of inappropriate substance use or addiction (family history and personal history)

- ☐ Alcohol
- ☐ Cannabis
- ☐ Prescription medications
- ☐ Over the counter medications
- ☐ Illicit drugs
- ☐ Other
- ☐ Any altered routes for consuming medications

Complete the Prescription Opioid Misuse Index (POMI) (patients who score 2 or more are more likely to be at risk for opioid use disorder; based on professional judgment, referral to another healthcare provider may be warranted for further assessment)

1. Do you ever use more of your medication, that is, taking a higher dose, than is prescribed for you?	☐ Yes ☐ No
2. Do you ever use your medication more often, that is, shorten the time between doses, than is prescribed for you?	☐ Yes ☐ No
3. Do you ever need early refills for your pain medication?	☐ Yes ☐ No
4. Do you ever feel high or get a buzz after using your pain medication?	☐ Yes ☐ No
5. Do you ever take your pain medication because you are upset, using the medication to relieve or cope with problems other than pain?	☐ Yes ☐ No
6. Have you ever gone to multiple physicians, including emergency room doctors, seeking more of your pain medication?	☐ Yes ☐ No

TOTAL ____

Goals of Therapy

1.

2.

3.

4.

5.

Recommendations

Drug Therapy Problem	Recommendation	Recommendation Implemented?

Education

☐ Pharmacological
☐ Non-pharmacological
☐ Adverse effects management
☐ Opioid safety (including proper storage/disposal)
☐ Education on opioid-induced respiratory depression
☐ Naloxone kit offered
  ☐ Naloxone kit dispensed
☐ Other

Action Plan (3-5 goals to be worked on prior to next appointment)

e.g., Walk to the mailbox once per week within 4 weeks.

1.

2.

3.

4.

5.

Follow Up
Date Scheduled for 1st Follow-up Consultation (Note: study deadline is Sept 13, 2024. Use professional judgment, general recommendation for follow-up is within 4-6 weeks) (YY/MM/DD): **Method of Contact:** ☐ In Pharmacy ☐ Phone: ☐ Other: **Monitoring and Follow-up Plan:** (for adherence, control and management of condition, any adverse effects, etc.)

Pharmacist	
Name:	**OCP Registration Number:**
Pharmacy Information:	
Consultation Duration:	**(minutes)**

References:

1. Lam C, Marr P, Leblanc K, Papoushek C, Kwan D, Sproule B, Murphy L. Physician and nurse practitioner perspectives of a modified Routine Opioid Outcome Monitoring (ROOM) Tool. *J Prim Health Care*. 2023. https://doi.org/10.1071/HC23022
2. Knisely JS, Wunsch MJ, Cropsey KL, Campbell ED. Prescription Opioid Misuse Index: a brief questionnaire to assess misuse. *J Subst Abuse Treat*. 2008;35(4):380-386. doi:10.1016/j.jsat.2008.02.001