Suggested opioid management assessment schedule

What you are assessing	How to assess	How frequently to assess
Specific diagnosis for pain Check that the patient has a diagnosis for their pain that will benefit from opioid medication.	Based on history, physical examination, and testing (e.g., labs, imaging, as indicated)	First acute, subacute, and chronic pain visit and then at visits according to risk level
Progress in meeting functional goals	Pain, Enjoyment, General activity scale (PEG), documented patient-set goals (e.g., walk to the park), reports by family (though not always reliable, can be useful), evidence of performing job or life role function	Every visit when opioids are prescribed
Potential benefits of non-opioid therapies	Diagnosis, history, patient's perspective, evidence (See integrative medicine table and "Nonopioid Treatments for Chronic Pain")	First acute, subacute, and chronic pain opioid prescription visit and then at visits according to risk level
Benefits and risks of continued opioid therapy	Based on history, PEG, MED, COMM, STOPBang, PDMP, UDT	A visit within 1 to 4 weeks of: • First chronic pain opioid prescription • Increasing the dose of a chronic pain opioid prescription
Potential for substance/opioid misuse, abuse, or disorder	Potential tools to use: ORT, ORT-OUD*, SOAPP, COMM, DAST, TAPS, DSM-5	First subacute or chronic pain visit
Current substances used, including sedatives **(e.g., benzodiazepines, carisoprodol)**	UDT (*Interpreting results*)	First subacute or chronic pain visit and then visits according to risk level
Current medications filled, including sedatives **(e.g., benzodiazepines, carisoprodol)**	PDMP	First opioid prescription, at each transition to a new pain category (acute, subacute, chronic), and then at visits according to risk level
Informed consent	Review the patient agreement and have the patient sign it	Start of long-term opioid therapy; annually
Morphine equivalent dosing	MED calculator	First opioid prescription and every change in opioid prescription
Anxiety, depression	PHQ, GAD-7	According to risk level
PTSD	PC-PTSD	If elevated PHQ or GAD despite active treatment
Sleep apnea	STOPBang (obstructive sleep apnea) Epworth (central sleep apnea)	When co-occurring risks: MED ≥ 50, Concurrent use of benzodiazepines , COPD, restrictive lung disease, including kyphosis or thoracic scoliosis, BMI > 28, snoring, fatigue, witnessed irregular breathing
Fibromyalgia	Patient self-report tool	As appropriate if pain is widespread and co-occurring symptoms such as fatigue, poor sleep, depression, abdominal and/or urogenital pain during diagnosis

* Note: *the ORT is validated for predicting risk of aberrant drug related behaviors while the ORT-OUD is validated for risk of developing opioid use disorder. See this article for more information.*

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