

PATIENT ASSESSMENT FOR OPIOID AGONIST TREATMENT

			Patient Name: PHN:(Or affix label here)
suc	comprehensive patient history and assessment should be take th treatment is indicated and appropriate. The following checkl tte:		prior to prescription of opioid agonist treatment, to ensure that provides guidance for a thorough assessment.
Bio	opsychosocial History	Me	ledical History
	Prior drug treatment (pharmacological, detox, residential treatment, support groups, counselling, relapse prevention) Screen for process addiction such as sex, crime, spending, or gambling Legal history and current legal issues		Surgical history Medications Allergies
	Financial concerns Employment history		tarting OAT
	Family history Social/emotional supports Additional areas of concern for patient (e.g., sexual abuse, violence, child at risk, unsafe sex, other)		for OUD Assess and document stage of change
Note: A trauma-informed framework should be used when taking this history. The patient may not be comfortable talking about all of these topics until a positive working relationship and safety have been established. It is not required to have a complete biopsychosocial history in order to start OAT.			Check PharmaNet to avoid duplication of prescriptions and drug interactions with current medications Document rationale for therapeutic choices (methadone vs buprenorphine)
Substance Use		Tests and Examinations	
	Substance use history including type of drug, amount, route, age of first use, frequency of drug use, last use Withdrawal symptoms Overdose history Drug costs per day and source of money Document discussion regarding avoiding alcohol and respiratory depressants such as benzodiazepines		Hepatitis C test Liver function test Urine drug test confirming opioid use Sexually transmitted infections screen Physical examination: intoxication, withdrawal, track marks

More information: www.bccsu.ca







