Essential Communication Elements Opioid Checklist

Pain diagnosis	YES ☐ NO ☐
Pain category(s) or classification	YES ☐ NO ☐
Temporal characteristics	YES ☐ NO ☐
Pain severity, recent	YES ☐ NO ☐
Pain severity, current	YES ☐ NO ☐
Drug name, dose, strength, formulation, route, and frequency for entire current daily medication regimen	YES ☐ NO ☐
Opioid doses administered within the last two 24 hour periods	YES ☐ NO ☐
Identification of opioid naïveté in patients starting on an opioid.	YES ☐ NO ☐
Presence, frequency, and degree of use of respiratory depressants (benzodiazepines, cough syrup containing alcohol, etc.)	YES ☐ NO ☐
History of opioid overdose with date(s).	YES ☐ NO ☐
Contact information provided for the subsequent pain management prescriber/physician.	YES ☐ NO ☐
Alcohol and/or substance abuse and/or dependence history	YES ☐ NO ☐
Behavioral health/mental health history and status	YES ☐ NO ☐
Respiratory status	YES ☐ NO ☐
Date of last bowel movement	YES ☐ NO ☐
Bowel regimen ordered	YES ☐ NO ☐
Presence of potential barriers to safe medication use (e.g., cognitive impairment, mental health disorders, dementia, visual impairment, etc.)	YES ☐ NO ☐
Fall assessment and history	YES ☐ NO ☐
Assessment of patient ability to self-administer current pain regimen	YES ☐ NO ☐
Patient/caregiver/ family member capacity for identifying signs/symptoms of overdose	YES ☐ NO ☐
Caregiver/family member capacity for administering a reversal agent for overdose if reversal agent is available	YES ☐ NO ☐
Instruction to follow safe usage, storage and disposal procedures for the prescribed medication for patients being discharged to home	YES ☐ NO ☐
Documentation of provision of educational materials to patient/caregiver	YES ☐ NO ☐
Assessment of patient/caregiver understanding of the education documented	YES ☐ NO ☐

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