OREGON DEPARTMENT OF CORRECTIONS
Operations Division
Health Services Section Policy and Procedure #P-G-01

SUBJECT: SPECIAL NEEDS TREATMENT PLANS

POLICY: Patients who have special needs or chronic illnesses shall be monitored by health care personnel at regular intervals to assure continuity and quality of care. Included among special needs patients are the following: the chronically ill, the physically disabled, frail or elderly patients, the terminally ill, those with serious communicable diseases, patients with serious mental health needs or developmentally disabled or pregnant patients.

A written treatment plan will include the following: Medication, the type and frequency of diagnostic testing, and the frequency of follow-up and adjustment of treatment modality. The plan includes diet, exercise when appropriate, and adaptation to the correctional environment as appropriate for the individual patient's needs.

REFERENCE: OAR 291-124-050 (5)
NCCHC Standards P-G-01 and Y-33
ACA 3-4355

PROCEDURE:

A. The nurse processing physician orders will input the identified special needs patient in the "Special Needs" category of the AS400 Inmate Health Plan (IHP).

1. Select option #4, press enter.
2. Input the patient SID number, press enter.
3. Press F6 to create a chronic condition, if the condition is not already inputted.
4. For correct code, press F4 and scroll down to select and press enter.
5. Press F10 to write a narrative note. This field can be used for a synopsis of follow-ups, medications, patient teaching, etc.

B. An appointment with a treating practitioner will then be made by using the "Schedule Inmates" of the IHP.

1. Select option #2.
2. Tab to provider field and input code, press enter (pressing F4, when the cursor is at the provider field will give a list of provider's codes).
3. Press F14 (Shift, F2). This will show selected provider's schedule on the calendar in the upper right-hand corner of the screen.
4. Press F8 to advance to the highlighted days. The cursor will position itself to the SID # field.
5. Input the patient's number.
6. Tab to the time field and input military time.

7. Tab to the next field, the condition field, and input the chronic condition code.
8. Tab to extra and input Y. This will give you a longer appointment.
9. Tab to the next field and input "Special Needs treatment planning."
10. Tab to location and input place of appointment.
11. Press enter twice and the patient is now scheduled.

C. The frequency of special needs clinics for patients with chronic illnesses has been established for stable patients. Patients may be monitored more frequently than required by this policy as determined necessary by the responsible treating practitioner.

Chronic illnesses include, but are not limited to:	Frequency of Clinic:
1. Asthma/Respiratory	Each four months
2. Diabetes	Each four months
3. HIV/AIDS	Each three months
4. Hypertension/Cardiovascular Diseases	Each four months
5. Seizure Disorders	Each four months
6. End-Stage Renal Disease/Dialysis	Each four months
7. Miscellaneous chronic illness	Each four months

D. Special needs not included in the above chronic illnesses will be seen by a treating practitioner or other appropriate provider for follow-up appointments every 4 months and will have a yearly special needs plan completed, *unless stipulated otherwise*, which will serve as that patients individualized treatment plan.

1. **Serious ongoing communicable diseases**.

2. **Physical disabilities** can refer to mobility impairments (e.g., amputations, paraplegia) or to other disabilities that limit a person's daily functioning, e.g. severe/significant visual, hearing or speech impairments.

3. **Frail or elderly patients** include those who suffer from conditions that impair their ability to function to the extent that they require assistance in activities of daily living.

4. **Pregnant patients** will be followed according to procedures in P&P #'s P-G-07, Care of the Pregnant Inmate and P-G-10, Pregnancy Counseling.

5. **Serious mental health needs** include those with basic psychotic disorders, mood disorders; self-mutilators; the aggressive mentally ill; and suicidal patients. **Schedule follow-up appointment each four months.**

6. **Developmentally disabled patients** who may need habilitation planning, assistance in accepting the limits of their condition and special attention to their physical safety in the corrections environment.

7. **Juveniles sentenced as adults** shall have an annual health appraisal.

E. The nurse assisting with the special needs clinic is responsible for assuring that all scheduled patients are seen. "No shows" or refusals are to be noted on the IHP and discussed with the practitioner for clinical review and further instructions. Documentation of this chart review will be made by the practitioner.

F. Laboratory requirements for special needs clinic visits shall be automatically scheduled by the nurse according to Nursing protocol SPECIAL NEEDS SCHEDULING AND LABORATORY or individualized treatment plan. These are to be done prior to the special needs clinic appointment, when possible, to allow for a review of the data at the time of the patient encounter with the practitioner.

G. Each special needs health encounter shall be documented in the patient's health care record by the practitioner. Prior to the appointment, the nurse will affix the special needs stamp on the progress sheet to alert the practitioner that this is a special needs visit. Multiple special needs clinic requirements may be met and combined during one encounter for greater efficiency.

The focus of the appointment however is the patient's special medical needs. Medical problems not related to the special needs may be dealt with at another appointment.

H. Follow-up appointments are scheduled via the "Schedule Inmates" of the IHP, following the same process listed in C. of this policy.

I. Nurses may be assigned to follow special needs patients to help assure compliance with medication, diet and the special needs treatment plan in between practitioner visits. Physical exams shall be performed by a physician, physician assistant or nurse practitioner, unless specifically indicated otherwise in this policy. Fundoscopic exams may be performed by the practitioner and do not necessarily require the services of an optometrist.

J. A patient may be dropped from the Special Needs clinic list if they have been asymptomatic subjectively and objectively (including labs) for one year while off of all medications or treatments for that year and their primary practitioner so orders in the physicians orders.

K. As patients are transferred to other Department of Corrections facilities, the receiving nurse is responsible for scheduling special needs patients for follow up clinic appointments as indicated.

Effective Date: _____
Revision date: August 2007
Supersedes P&P dated: November 2006

PRACTITIONER GUIDELINES FOR SPECIAL NEEDS CLINICS

If a patient is free from all signs and symptoms of a specific disease for one year without medication, they may be removed from that special needs clinic.

ASTHMA / RESPIRATORY

A. Baseline

1. History: asthma overall severity, activity tolerance, recent medications, recent symptoms, nighttime symptoms, number of hospitalizations and emergency room visits, other risk factors.

2. Physical examination: respiratory system, observation and auscultation.

3. Laboratory: pulmonary function test or Peak Expiratory Flow Meter and theophylline level, if applicable.

4. Treatment: medication, if applicable, patient education, special needs (slow walk, lower tier, no stairs, etc.).

B. Clinic

1. Frequency: at least every four months.

2. Requirements per clinic visit: interim history of symptoms, lung auscultation, Peak Flow Meter, theophylline level (if applicable), types and amounts of medication used past four months.

3. Treatment: note medication, patient education.

DIABETES MELLITUS

A. Baseline

1. History: IDDM vs. NIDDM, food and alcohol consumption, family history, medications and diet on streets.

2. Physical examination: To include funduscopic examination, brief circulation evaluation with attention to lower extremities, and brief neurological examination, to screen lower extremity sensation.

3. Laboratory: fasting blood sugar (FBS), hemoglobin Alc, triglycerides, cholesterol, BUN, and creatinine (Chem plus and HbAIC).

B. Chronic Needs Clinic

1. Frequency: at least every four months.

2. Requirements per clinic visit: blood pressure, weight, and review of Accu-check or other pertinent blood glucose data.

3. Treatment: note any changes in medication, diet, and patient education.

4. Annual clinic requirements: funduscopic examination and repeat baseline laboratory.

HIV

A. Baseline

1. History: obtain documentation of HIV status. Current symptoms. Any previous treatment for HIV disease or opportunistic infections. TB status, Hepatitis status, chronic medical conditions.

2. Physical examination: weight, temperature, blood pressure, funduscopic examination, lymphadenopathy, organomegaly, skin lesions, mental status, cough.

3. Laboratory: CBC, chemistry panel, CD4 count, viral load, RPR, Hepatitis B surface antigen, Hepatitis B surface antibody, Hepatitis C antibody.

B. Chronic Needs Clinic

1. Visit every three months.

2. Lab requirements at each clinic are CBC, chemistry panel, CD4 count and viral load.

3. Annual clinic visits are the same as the quarterly visits.

HYPERTENSION / CARDIOVASCULAR

A. Baseline

1. History: presence of risk factors, family history, smoking, diet and exercise.

2. Physical examination: weight, cardiovascular system, blood pressure (sitting and standing), pulses, determination of presence of bruits, and funduscopic examination (may be done by primary care practitioner).

3. Laboratory: electrocardiogram (EKG), BUN, creatinine, electrolytes if on diuretic medication, and cholesterol/triglycerides, LDL/HDL.

4. Treatment: medication, therapeutic diet (if applicable), patient education (diet, risk reduction, exercise, and smoking), and evaluation of special placement, program, and/or assignment needs (slow walk, lower tier, work restrictions, etc.).

B. Clinic

1. Frequency: at least every four months.

2. Requirements per clinic visit: examination of heart, weight, blood pressure, pulses.

3. Annual clinic requirements: same as Baseline.

SEIZURE DISORDER

A. Baseline

1. History: etiology and seizure history (frequency and types), obtain available documentation.

2. Physical examination: neurological examination, and if on phenytoin, observation for side effects.

3. Laboratory: anti-convulsant medication blood level and CBC.

4. Treatment: anti-convulsant medication, patient education, and evaluation of special placement needs.

B. Clinic

1. Frequency: at least every four months.

2. Requirements per clinic visit: examination (neurological and observation for side effects and documentation of presence or absence); and laboratory (medication blood level), interim history.

3. Treatment

a. Anti-convulsant medication, as indicated.

4. Annual clinic requirements: CBC.

TUBERCULOSIS

See TB Protocol. Frequency: Intake and Yearly Screening.

Major Illnesses (History/Interval history, Risk factors, ADL adaptations, etc.)
Significant Medication History
Hospitalizations/Surgeries
Lab and Diagnostic Findings
Physical Exam
Tetanus _____ Influenza Vac _____ Other _____ Pneumovax _____ Hep B Vac _____

Name_____

SID #_____

DOB_____

ASTHMA / COPD

Date			
Exacerbations Recent Sx History			
Medications			
Physical Exam			
PEFR or % PEFR			
Classification			
Control			
Status			
Plan			

Control – good	Control – Fair	Control – Poor	Status – Improved	Status-Unchanged	Status-Worsened
$\leq$ 1 β agonist MDI refill per month No on-site visit for Emerg. care No night awakening with asthma symptoms	$\leq$ 1 β agonist MDI refill per month $\leq$ 1 on-site visit for Emerg. Care $\leq$ 1 weekly night awakening with asthma	> 1 β agonist MDI refill per month > 1 on-site visit for Emerg. care > 1 weekly night awakening with asthma	Less use of β agonist MDI and less frequent symptoms.	Both β agonist MDI use and frequency of symptoms are unchanged since last visit.	Greater use of β agonist MDI, more acute symptoms, or an increase in Emerg. visits.

Recommended Medications by Level of Severity: Adults
All levels of severity, in addition to any regular daily controller therapy, rapid-acting inhaled beta2-agonist should be taken as needed to relieve symptoms, but should not be taken more than 3 to 4 times a day. One inhaler should last 30-90 days

Level of Severity: Step 1. Intermittent asthma*
Daily Controller Medications**:** None necessary
Level of Severity: Step 2. Mild Persistent Asthma
Daily Controller Medications: Inhaled glucocorticosteroid **
Other Treatment Options: Sustained-release theophylline, OR,Cromone, OR, Leukotriene modifier
Level of Severity: Step 3. Moderate Persistent Asthma
Daily Controller Medications:
Inhaled glucocorticosteroid PLUS long-acting inhaled beta2-agonist
Other Treatment Options:
Inhaled glucocorticosteroid PLUS sustained-release theophylline, OR
Inhaled glucocorticosteroid PLUS long-acting oral beta2-agonist, OR
Inhaled glucocorticosteroid at higher doses***, OR
Inhaled glucocorticosteroid PLUS leukotriene modifier
Level of Severity: Step 4. Severe Persistent Asthma
Daily Controller Medications**:**
Inhaled glucocorticosteroid PLUS long-acting inhaled beta2-agonist,
PLUS one or more of the following, if needed:
Sustained-release theophylline
Leukotriene modifier
Long-acting oral beta2-agonist
Oral glucocorticosteroid

All Steps: Once control of asthma is achieved and maintained for at least three months, a gradual reduction of the maintenance therapy should be tried in order to identify the minimum therapy required to maintain control.

* Those with intermittent asthma but severe exacerbations should be treated as having moderate persistent asthma.
** Corticosteroid inhaler – Start with Triamcinolone 2 puffs BID or Beclamelthasone 2 puffs BID (one inhaler should last 60 days at this dosage). Increased Steroid inhaler dosage is Triamcinolone 4 puffs BID or Beclamethasone 4 puffs QID.
*** Increased cortisone inhaler dosage to 12 – 16 puffs per day, consider Fluticasone (Flovent) 110 mcg where one puff has therapeutic equivalency to 4 puffs triamcinolone.

Severity Scale

STEP 1: Intermittent	**STEP 2: Mild Persistent**	**STEP 3: Moderate Persistent**	**STEP 4: Severe Persistent**
Symptoms < once a week Brief exacerbations Nocturnal ≤ twice a month FEV_1 ≥80% predicted or PEF ≥80% of personal best PEF or FEV_1 variability <20%	Symptoms > once a week but <once a day Exacerbations may affect activity and sleep Nocturnal symptoms > twice a month FEV_1 ≥80% predicted or PEF ≥80% of personal best PEF or FEV_1 variability 20% to 30%	Symptoms daily Exacerbations may affect activity and sleep Nocturnal symptoms ≥ once a week Daily use of inhaled short-acting beta2-agonist FEV_1 60% to 80% predicted or PEF 60% to 80% of personal best PEF or FEV_1 variability >30%	Symptoms daily Frequent exacerbations Frequent nocturnal asthma symptoms Limitation of physical activities FEV_1 ≤60% predicted or PEF ≤60% of personal best PEF or FEV_1 variability >30%

DIABETES

Date				
Subjective				
Meds/dosage				
Glucose ranges [1]				
BP [2]/Pulse				
Wt/Ht or BMI				
Exam				
LE sensation/circulation [3]				
Dilated eye exam [4]				
Urine protein [5]				
BUN / CR				
HgbA1c [6]				
Trig/HDL/LDL[7]				
Activity/Education/Diet/ Housing/other				
Control	Diabetes[8]			
	BP*****			
	Lipids*****			
Status	Diabetes[9]			
	BP*****			
	Lipids*****			
Assessment/Plan				

***** Must only report if not at goal without treatment (BP <130/80 and Lipids; LDL < 100

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Diabetic Guidelines

1. Glucose range: The American Diabetes Association (ADA) and NCCHC goal is a fasting glucose range of 90-130 mmHg.

2. BP: ADA, Joint National Commission 7, NCCHC, and American Heart Association recommend: Goal BP <130/80 mmHg. If BP $\geq$ 140/90 mmHg then start treatment and behavioral therapy. If 130-139/80-89 mmHg then 3-6 months behavioral therapy before medications. Initial drug therapy should be an ACE or ARB. A diuretic should be the 2nd drug added if the ACE or ARB is insufficient. Drug therapy should be with a drug class shown to reduce cardiovascular death events (ACE, ARB, diuretic, B-blocker, and calcium channel blockers).

   BP Control- **Good**; <130/80, **Fair**; $\leq$ 140/90, **Poor**; > 140/90.

3. Feet: Should be screened yearly for circulation, sensation to monofilament, skin integrity, and structural problems. Feet should be visually seen at every diabetes visit.

4. ADA standards are a dilated eye exam within 5 years of type 1 DM onset and at diagnosis of type 2 DM. Thereafter screening at 1-3 years at the discretion of the optometrist, ophthalmologist, or qualified provider is acceptable.

5. Urine protein should be screened at least yearly at diagnosis of type 2 and of $\geq$ 5 years duration of type 1. The microalbumin or spot protein/Cr method is preferred by most experts and first am voiding most reliable. Exercise within 24 hours, infections, fever, CHF, marked hyperglycemia, and marked hypertension may elevate results. Normal is <30 mcg/mg, microalbuminuria 30-299 mcg/mg, and Macro (clinical) albuminuria $\geq$ 300 mcg/mg. At least 2 out of 3 samples over 3-6 months should be abnormal before a diagnosis is made. An ACE or ARB is primary treatment. Non-DCCB's (verapamil), B-blockers, and diuretics are preferred secondary choices. Dietary protein restriction to ~10% of daily intake may slow progression once patients have diabetic nephropathy.

6. HgbA1c is the primary target for diabetes control. ADA HgbA1c goal is <7.0%. Test at least every 6 mo's if at goals and treatment stable. Test quarterly if therapies change or patient not at goals. Aggressive control with insulin may reduce morbidity in severe acute illness, pregnancy, peri-operatively, and after acute MI. Less stringent control may be appropriate for patients with a history of severe hypoglycemia, limited life-spans, young children, older adults, and those with co-morbid conditions.

7. Lipid goals are: LDL <100, HDL $\geq$ 40, and Triglycerides <150. Some authorities now recommend LDL < 70 mg/dl for diabetics with established CHD. Statins are drug of choice. Niacin at <2000 mg/day is compatible with DM 2, but may worsen control. Testing can be yearly unless low risk (LDL <100 mg/dl, Triglycerides (TG) < 150 mg/dl, HDL > 50 mg/dl) when it can be repeated every 2 yrs.

8. **Lipid Control**- **Good**; LDL < 100, **Fair**; LDL 100-130, **Poor**; LDL > 130.

9. **Diabetes Control**- **Good**; HgbA1c < 7, **Fair**: HgbA1c 7-8%, **Poor**; $\geq$ 8%.

10. **Status-** **Improved**: Reduced HgbA1c or finger-stick averages, or for DM 2 intentional weight loss from diet/exercise $\geq$ 5%.

    Unchanged: HgbA1c's, average finger-sticks, and weight are relatively unchanged.

    Worsened: Worse HgbA1c or finger-stick averages, or for DM 2, weight gain $\geq$ 5 %.

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Epilepsy/Seizure Disorder

Specify Diagnosis_____Verification of Diagnosis?/Method?_____

Date			
Subjective			
Med(s)/Dosage			
Seizure frequency since previous evaluation Verified (yes/no) Description (Classical/Atypical)			
Seizure Free Interval (Time since last seizure)			
Opportunity to stop Medication? (Yes/No)			
Directed Exam			
Medication Level(s)			
Hemoglobin/Hematocrit WBC/Platelets			
AST/ALT			
BUN / CR			
Environmental Controls Bunk/Work/etc.			
Medication Compliance/ Side Effect			
Control			
Status			
Plan			

Clinic	Good Control	Fair Control*	Poor Control*	Improved Status	Unchanged Status	Worsened** Status
Epilepsy	No Seizures during interval	One seizure during interval	More than one seizure during interval	Fewer Seizures than prior visit	The same number of Seizures	More Seizures than prior visit

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Management Overview

- Use of a single drug as few times a day as appropriate and with the fewest side effects is preferred.
- The goal of therapy is complete seizure control without unacceptable side effects.
- The diagnosis of epilepsy must be verified and alternate diagnoses must be excluded. Often inmates may be misclassified as having epilepsy when their seizures are secondary to alcohol and other drugs. When old records are not available, consider re-establishing the diagnosis, or trial off medication (see below).
- Patients with alcohol and drug related seizures or withdrawal seizures do not require treatment with anti-epilepsy drug(s) (AED) once the seizure has been treated or the withdrawal has abated.
- Head injuries with post-traumatic seizure disorder are also common in alcoholics and may be impossible to differentiate from withdrawal seizures. When in doubt, it may be appropriate to continue chronic AED treatment.
- If a patient has not had a seizure for a minimum of two years, the provider, with patient collaboration, may consider discontinuing medication therapy with close patient follow-up (see below).

Correctional Barriers

- Crowding and secondary gain may encourage false reporting of epilepsy in attempts to obtain low bunks, special work assignment, or other perceived benefits.
- Where Pseudoseizures are a concern, direct observation in an infirmary setting should be considered.
- Many patients may enter a system misdiagnosed with epilepsy when they may only suffer alcohol or other drug related or withdrawal related seizures.
- Documented seizures may be under-reported.
- Non-Compliance or issues with medication availability may interfere with appropriate treatment.
- Consider directly observed therapy if suspected non-compliance in a poorly controlled epilepsy patient.

Routine Laboratory Test – Initially and Periodically

- Drug Levels (Phenobarb, Dilantin, Tegretol, Depakote) At least annually even if good control.
- Complete blood count (CBC) and Chemistry panel (CMP) at least annually.
  More frequently if new med or dosage change.

Definitions of Seizure Control

- Good Control is characterized by an absence of seizure activity since prior visit.
- Fair Control is characterized by one seizure since the last visit.
- Poor Control is characterized by more than one seizure since last visit.
- Refractory Seizures defines seizures chronically in the poor control category. These patients usually should be seen by a neurologist periodically.

Definitions of Status/Seizure Frequency

- Improved status is when the number of seizures has diminished since the patient's last visit.
- Unchanged status is when the frequency of seizures since the last visit has remained the same.
- Worsened status is when the number of seizures has increased since the last visit.

Environmental Controls

- Patients with recurrent seizures should be counseled about or removed from potentially hazardous work assignments (e.g. Use of power equipment).
- Patients with a history of recurrent seizures should be assigned to a low bunk.
- If pseudo-seizure is suspected, consider direct observation in an infirmary setting.

Discontinuation of seizure medication can be considered if patient fits the following profile:

- Seizure free a minimum of two years on antiepileptic drugs.
- Single type of partial or generalized seizure.
- Normal neurological exam and patient intelligence.
- Normal EEG with treatment.

Hepatitis C Evaluation Worksheet

** Date patient requested Hepatitis screening (if after 9/1/06) ** _____

SECTION 1 Initial Screening Information (Complete within 30 days of **date)			Date
HCV antibody positive?	□ Yes	□ No	
Time left to serve greater than 12 months?	□ Yes	□ No	
ALT Values Baseline Result _____Date_____ Repeat six months Result _____ Date_____	Repeat 12 months Result _____ Date _____ Repeat 18 months Result _____ Date _____		
If baseline ALT is abnormal and patient has 12-18 months to serve, obtain Hepatitis C Genotype. **Genotype** _____Date _____ If type 1 or 4, pt needs 18 months to serve, if type 2 or 3, 12 months is sufficient to complete treatment and follow-up.			
Is patient an appropriate candidate for further evaluation for possible treatment with Interferon and Ribavirin? ***If yes, proceed to Sections 2, 3, and 4. If no, give reason.***	□ Yes	□ No	

INSTRUCTIONS—General Principles

1. Refer to ODOC - Health Services "Medical Guidelines for Hepatitis C Evaluation and Treatment" for details on the evaluation of patients who are Hepatitis C antibody positive. The instructions that follow are intended as a general guide to using this form only.

2. If patient paroles or his status regarding Hepatitis C has otherwise changed, initiate a new form.

3. Date at top of page. Enter the date the patient requested Hepatitis Screening or the date the patient arrived at the first facility after intake, if patient requested screening after 9/1/06.

4. Section 1—Based on current ODOC - Health Services policy/protocol, decide if patient needs further evaluation for possible liver biopsy and treatment. If the patient has normal ALT or less than 12 months sentence to serve, patient generally would not proceed to liver biopsy. Patients who are Hepatitis C antibody positive and have normal liver enzymes can generally safely have ALT monitoring only, but they still should have an initial medical evaluation for the possible presence of liver cirrhosis.

5. Section 2, 3, and 4 should be completed concurrently, and usually within three months of the date at the top of the form. Avoid unnecessary delay in determining if the patient is an appropriate treatment candidate based on more complete medical information. There are absolute and relative contraindications to treatment with Interferon and Ribavirin. (See "Medical Guidelines for Hepatitis C Evaluation and Treatment".) History, examination, and laboratory evaluation should help to determine if these exist or not.

6. Section 5—Make a decision about the appropriateness of proceeding to liver biopsy and treatment for this patient based on current medical information. Generally you should be able to make this decision within four months of the date at the top of the form. If you are undecided because you need more information, you may defer biopsy, but always document your clinical decision making process if you are not proceeding to Section 6.

7. If, after completing sections 2, 3, 4, and 5, you consider your patient appropriate medically to proceed to liver biopsy, proceed to section 6. Bring all clinical information to TLC meetings for consideration by the committee.

8. If, after completing sections 2, 3, 4, and 5, there are medical or other contraindications to liver biopsy, or if biopsy has already occurred, the patient should be followed clinically. Monitor patient at least annually for any change in status. (See form "Hepatitis C Monitoring".)

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SECTION 2 Further Medical Evaluation			Date
Directed History and Exam shows evidence of serious hepatic illness.	□ Yes	□ No	
Evidence of decompensated liver disease or clinical evidence of cirrhosis, e.g., ascites, history of hepatic encephalopathy, history of esophageal varices, etc.	□ Yes	□ No	
HIV/AIDS (HIV Ab positive)?	□ Yes	□ No	
Major Medical Illness poorly controlled, e.g. Diabetes, ASCVD, Angina, COPD, Thyroid, Mental Health Issues, Cancer, Autoimmune Disorder, etc. Explain.	□ Yes	□ No	
Lab Evaluation (Do CBC, Metabolic Profile, INR, TSH, ANA, HIV testing). Any significant Abnormalities? Explain.	□ Yes	□ No	
SECTION 3 Mental Health Considerations			Date
Major mental illness poorly controlled?	□ Yes	□ No	
Evidence or history of suicide ideation and/or suicide attempt?	□ Yes	□ No	
History of severe psychiatric disorder?	□ Yes	□ No	
CTS referral for evaluation indicated/ordered?	□ Yes	□ No	
Recent aggressive behavior problems?	□ Yes	□ No	
SECTION 4 Other Concerns			Date
Evidence of concerns with risk behaviors?	□ Yes	□ No	
Evidence of non-compliance with treatment or evaluations?	□ Yes	□ No	
Patient refused to sign contract?	□ Yes	□ No	
Specialty Consult Needed? Explain. If obtained, note results.	□ Yes	□ No	
Other Concerns? Explain.	□ Yes	□ No	
SECTION 5 Clinical Decision making (Complete within 120 days of **date)			Date
Is patient an appropriate candidate for possible liver biopsy and treatment with Interferon and Ribavirin? ***(If YES, proceed to Section 6—Biopsy and Treatment)***	□ Yes	□ No	
If patient is not an appropriate candidate at this time for liver biopsy and treatment, give reason: ***Proceed to Hepatitis C Monitoring***			
SECTION 6 Biopsy and Treatment			Date
Liver biopsy approved?	□ Yes	□ No	
Liver biopsy results ***(Obtain results within 180 days of **date)*** Grade _____ Stage_____ Genotype Results_____ (If not already done)			
Liver biopsy results to TLC	□ Yes	□ No	
Treatment with Ribavirin and Interferon approved by TLC? If yes, proceed to treatment. See "Treatment Monitoring" Form If no, proceed to "Hepatitis C Monitoring"	□ Yes	□ No	
HCV RNA results (Viral Load—Quantitative) _____ ***(Complete before starting treatment if Genotype 1 or 4)***			

Hepatitis C Monitoring

DATE			
Subjective			
Exam			
ALT/AST			
Other pertinent lab			
Possible Medical Contraindications or Barriers to Treatment with Ribavirin and Interferon (Check if Pertinent) **<u>Comments</u>**	O Major Medical O Major Mental Health O Risk Behavior for Hepatitis O No Liver Enzyme Elevation O Time to Serve O Decompensated Cirrhosis O Aggressive Behavior O Non-compliance O Liver Biopsy Results O Other	O Major Medical O Major Mental Health O Risk Behavior for Hepatitis O No Liver Enzyme Elevation O Time to Serve O Decompensated Cirrhosis O Aggressive Behavior O Non-compliance O Liver Biopsy Results O Other	O Major Medical O Major Mental Health O Risk Behavior for Hepatitis O No Liver Enzyme Elevation O Time to Serve O Decompensated Cirrhosis O Aggressive Behavior O Non-compliance O Liver Biopsy Results O Other
Interval Change			
Assessment			
Plan			

Refer to ODOC - Health Services “Medical Guidelines for Hepatitis C Evaluation and Treatment” for details on ongoing monitoring of patients who are Hepatitis C positive.

Hepatitis C Treatment Monitoring Form

INF/RBV Monitoring	Baseline	Wk1	Wk2	Wk3	Wk4	Wk8	Wk12	Wk16	Wk20	Wk24	Q4wk
CBC and Platelets											
Chem Panel (ALT, Alb, Bili)											
Pregnancy Test											
TSH											
Quantitative HCV – RNA (viral load) If genotype 1											
Qualitative HCV – RNA If genotype 2-3											

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HIV/AIDS (Circle one)

Date			
HIV Meds (HAART)			
Adherence/Side Effects			
Prophylactic meds			
Other Meds			
Co-Morbidity			
Symptoms			
Vitals/Weight			
General			
HEENT			
Lymph			
Chest/Lungs			
Abdomen			
Skin			
Neuro			
CD4 Total			
VL (Viral Load)			
CBC (note abnormals)			
AST/ALT			
Cholesterol/TG/HDL/LDL			
Control			
Status			
Plan			

	Control Good	Control Fair	Control Poor	Status Improved	Status Unchanged	Status Worsened
VL**	<75 if on ART <55,000 on no ART	75 - 1000 if on ART 55,000 on no ART	>1000 if on ART > 55,000 on no ART	VL down 0.5 log		VL up by 0.5 log or detectable after being <75
CD4**	>350	200-350	<200*	CD4 up by 25-50		CD4 down 30%
Overall Status**	Asymptomatic	Asymptomatic	Symptomatic	Symptoms better		HIV-related event 3 mos after start of HAART

* Patients with profound immunodeficiency may be unable to increase CD 4 over 200, but are well controlled with undetectable (<75) VL. In such cases, viral load is used to evaluate control.
**Discordant control parameters may occur. Generally, virologic precedes immunological precedes clinical failure. If a repeat test confirms failure in one of the parameters, obtain expert consultation.

Definitions of Antiretroviral Treatment (ART) Failure:

- Virologic failure:
  Failure to achieve VL <400 by 6 mos or <75 by 1 year. Most decrease VL by 1 log within 4 weeks
  Viral suppression followed by repeated positive VL.
- Immunologic failure:
  Failure to increase CD 4 by 25-50 in first year. Mean increase is 150/yr in treatment- naïve patients)
- Clinical failure:
  Occurrence or re-occurrence of HIV-related event >3 mos after start of HAART (Exclude immune reconstitution syndromes)

Initial History

- Risk Factor
- Date of first positive test/prior negative test dates
- CD4 nadir/date
- Opportunistic Infections (OIs) (specify)
- Co-infections (Hepatitis B, C, etc)
- Current ART or HAART (highly active ART)
- Prior ART (dates, agents, response (did VL become undetectable?, adverse reactions)
- Prior resistance testing
- Immunization History

Treatment

- The treatment of HIV/AIDS is rapidly evolving. The goal is durable viral suppression, immune reconstitution, improvement of quality of life, and reduction of HIV-related morbidity and mortality.
- Expert consultation is recommended when initiating/changing HAART.
- Patient education and involvement is essential, as regimens are complex, have side-effects and interactions, and less than perfect adherence can lead to drug resistance.
- CD4 is the main consideration in the decision to initiate treatment. Treatment should be offered to patients with asymptomatic AIDS (CD4<200), pregnancy, and symptoms of

HIV/AIDS, including acute HIV if highly symptomatic (if suspect, obtain viral load rather than antibody test to diagnose).

- Consider treatment in the asymptomatic patient with: CD4 of 200 to 350, especially if the viral load is >20,000 or CD4 >350 if VL >100,000
- If treat, goal is complete and durable viral suppression (<75).
- Evaluate response to treatment with VL; expect 1 log drop at 4 weeks and <75 at 4-6 mos.
- Regimen failure: assess adherence (cause, side-effects, interaction; consider directly observed treatment, simplified regimen, change w/in class or change class from PI- to NNRTI-based or vice versa; phenotypic resistance test if VL is 500-1000)
- Prevention of opportunistic infections and cancers may differ if primary (no history of the infection) or secondary (history exists) prophylaxis. Consult an expert or www.aidsinfo.NIH.gov/guidelines). Common OIs with indications for prophylaxis include MTB (PPD= or >5 mm for any CD 4 level), PCP (if CD4 <200 or oropharyngeal candidiasis), toxoplasmosis (if CD4 <100 and + Toxo IgG antibody), MAI (if CD4 <50). Prophylaxis decision is based on the most recent CD4 count.

Correctional Barriers

- Significant stigmatization is directed against HIV-infected individuals. The major barrier to care is maintaining confidentiality.
- Another barrier is cost of care. Medications and tests are expensive, but cost effective.
- Continuity of care may be problematic. Obtaining old records is helpful. A brief discharge summary at release can help. Every county health department in Oregon has an HIV case manager who can facilitate discharge and after care.

Routine Laboratory Tests

- Initially: CD4 count, 3rd generation B DNA VL, CBC, CMP, RPR, lipid panel, Chronic Hepatitis markers 6462, PPD, Pap. Consider baseline CXR, CMV and Toxo IgG antibody.
- Follow-up: CBC, CMP, and VL should be done quarterly or for symptoms. CD4 every 6 mos if >350 and stable. VL should be repeated more frequently if regimen changes or if there is a worsening of status.
- Annual PPD is mandatory.
- Paps annually or every 6 mos if CD4 <200.
- Eye exam every 6 mos. if CD4 <100
- Lipids 3-6 mos post initiation, then annually if on PIs

Immunizations

- Twinrix series; Td q 10 yrs; Influenza annually; Pneumovax q 6 yrs.

Environmental Controls

- To avoid stigmatization by peers, inmates with HIV may not work in the kitchen
- Certain protease inhiibitors should be taken with food (LPVr NFV SQV RTV ATV). Other antiretroviral medications (IDV and DDI) should be taken on an empty stomach
- Patient adherence should be encouraged and assessed at every visit.

CARDIOVASCULAR / HTN

Date			
Subjective			
BP/Pulse			
Meds / dosage			
Co-morbidities Compelling indications			
Ht. & Wt. or BMI**			
Lungs			
Heart			
Edema			
Bruits / Angina Claudication			
Glucose *			
LDL / HDL *			
K+ / NA+ *			
BUN / CR *			
Control			
Status			
Plan			

*indicates item to be done at least yearly

** BMI = Kg/m^2 or $(Lb/inch^2) \times 703.1$

Clinic	Good Control	Fair Control*	Poor Control*	Improved Status	Unchanged Status	Worsened** Status
Cardiac / HTN[1]	Systolic <140 mm/Hg. Diastolic <90 mm/Hg.	Systolic 140-160 mm/Hg. Diastolic 90-100 mm/Hg.	Syst >160 mm/Hg. Diast >100mm/Hg.	The patient's blood pressure reading is lower than at the previous SNR visit.	The blood pressure, weight, and/or baseline laboratory values have not changed since the previous SNR visit.	An increase in the patient's B/P, wt., lab values, non-adherence to treatment plan.
HTN + Diabetes[1,2] Renal Disease	Systolic <130 mm/Hg. Diastolic <80 mm/Hg.	Systolic 130-150 mm/Hg. Diastolic 80-95 mm/Hg.	Systolic >150 mm/Hg. Diastolic >95 mm/Hg.			

Physical Exam

- Two or more blood pressure readings separated by 2 minutes with the patient supine or seated.
- Verification in the contralateral arm (if values are different, the higher value should be used)
- Measurement of weight, height, BMI = Kg/m^2 or ($Lb/inch^2$) x 703.1
- Fundoscopic examination for hypertensive retinopathy (i.e., arteriolar narrowing, focal arteriolar constrictions, arteriovenous crossing changes, hemorrhages and exudates, disc edema)
- Examination for the neck for carotid bruits, distended veins, or enlarged thyroid gland
- Examinations of the heart for abnormalities in the rate and rhythm, increased size, precordial heave, clicks, murmurs and third and fourth heart sounds
- Examination of the lungs for rales and evidence for bronchospasm
- Examination of the abdomen for bruits, enlarged kidney, masses and abnormal aortic pulsation
- Examination of the extremities for diminished or absent peripheral arterial pulsations, bruits, and edema
- Neurological assessment

Laboratory Test

Initial

- Urinalysis (UA)
- Complete blood count (CBC)
- Chemistry panel (e.g., Chem 20)
- Fasting lipid profile (cardiac risk panel)
- Electrocardiogram (EKG)

Yearly

- Fasting lipid panel as indicated
- Chemistry panel (e.g., Chem 20)

Assess for Identifiable Causes of Hypertension

- Sleep apnea
- Drug induced/related
- Chronic kidney disease
- Primary aldosteronism
- Renovascular disease
- Cushing's syndrome or steroid therapy
- Pheochromocytoma
- Coarctation of aorta
- Thyroid/parathyroid disease

Principles of Lifestyle Modification

- Encourage healthy lifestyles for all individuals.
- Components of lifestyle modifications include weight reduction, DASH eating plan, dietary sodium reduction, aerobic physical activity, and moderation of alcohol consumption.

Modification	Recommendation	Avg. SBP Reduction Range
Weight reduction	Maintain normal body weight (body mass index 18.5-24.9 kg/m^2).	5-20 mmHg/10 kg
DASH eating plan	Adopt a diet rich in fruits, vegetables, and lowfat dairy products with reduced content of saturated and total fat.	8-14 mmHg
Dietary sodium reduction	Reduce dietary sodium intake to $\leq$ 100 mmol per day (2.4 g sodium or 6 g sodium chloride).	2-8 mmHg
Aerobic physical activity	Regular aerobic physical activity at least 30 minutes per day, most days of the week.	4-9 mmHg
Moderation of alcohol consumption	Men: limit to $\leq$2 drinks* per day. Women and lighter weight persons: limit to $\leq$1	

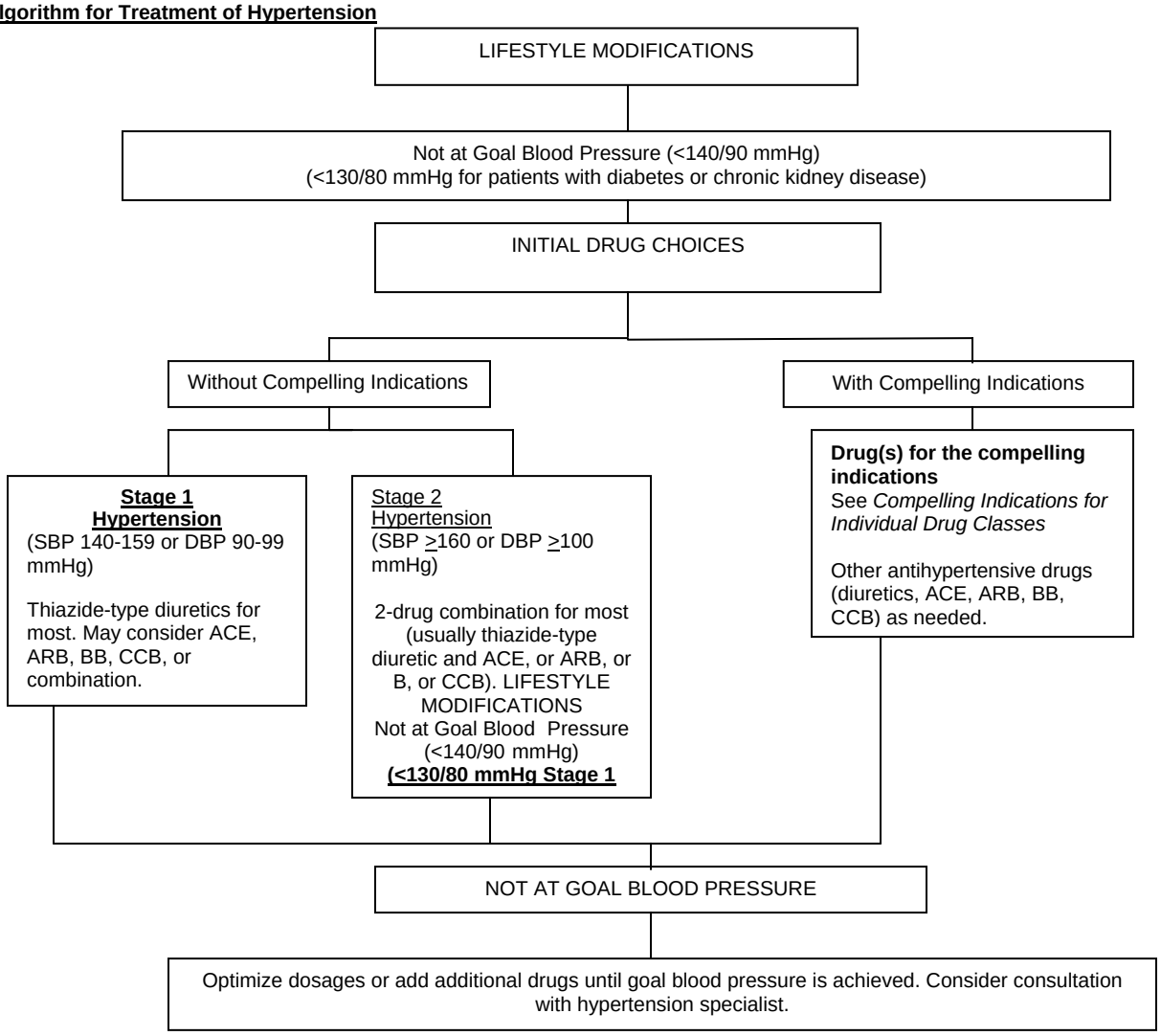
Effective: Oct. 2006

TREATMENT

Principles of Hypertension Treatment

- Treat to BP <140/90 mmHg or BP <130/80 mmHg in patients with diabetes or chronic kidney disease.
- Majority of patients will require two medications to reach goal.

Algorithm for Treatment of Hypertension



Compelling Indication	Initial Therapy Options
• Heart failure	THIAZ, BB, ACEI, ARB, ALDO ANT
• Post myocardial infarction	BB, ACEI, ALDO ANT
• High CVD risk	THIAZ, BB, ACEI, CCB
• Diabetes	THIAZ, BB, ACEI, ARB, CCB
• Chronic kidney disease	ACEI, ARB
• Recurrent stroke prevention	THIAZ, ACEI

Key: THIAZ – thiazide diuretic, ACEI = angiotensin converting enzyme inhibitor, ARB = angiotensin receptor blocker, BB = beta blocker, CCB = calcium channel blocker, ALDO ANT = aldosterone antagonist Compelling Indications for modification of initial Drug Classes

Causes of Resistant Hypertension

- Improper BP measurement
- Excess sodium intake
- Inadequate diuretic therapy
- Medication
  - Inadequate doses
  - Drug actions and interactions (e.g., nonsteroidal anti-inflammatory drugs (NSAIDs), illicit drugs, sympathomimetics, oral contraceptives)
  - Over-the-counter (OTC) drugs and herbal supplements
  - Excess alcohol intake
- Identifiable causes of hypertension

Effective: Oct. 2006

HYPERLIPIDEMIA

Date:			
Subjective			
BP/Pulse			
Weight/Ht or BMI			
Meds/dosage			
Exam			
BUN / CR *			
AST/ALT *			
Trig/HDL/LDL *			
Activity/Education/Diet / Housing/other			
Control[1]			
Status[2]			
Assessment/Plan			

*indicates item to be done at least yearly.

1. Control: Good- At or below ATP III goals, Fair- $\leq$ 30 from goal, Poor- > 30 from goal.
2. Status: Are lipids improved, unchanged, or worsened.

ATP III Lipid Guidelines[1]

Step 1: Determine complete lipoprotein profile after 9-12 hour fast.

Step 2: Identify those at high 10 year risk (>20%) for coronary heart disease (CHD): Clinical CHD, Symptomatic carotid artery disease, peripheral artery disease, abdominal aortic aneurysm, diabetes.

Step 3: Determine major non-LDL risk factors: Cigarette smoking, BP >140/90 or on medication, HDL <40 (>60 –1 risk factor), Family Hx CHD 1st degree relative male < age 55 or female <65, Age (male ≥ 45, female ≥ 55).

Step 4: If 2 or more risk factors present, and not identified as high risk above, determine 10 year CHD risk with Framingham tables (available on paper, PDA, and Excel spreadsheet versions).

Step 5: Establish **t**herapeutic **l**ifestyle **c**hanges (TLC), LDL goals, and LDL level for drug consideration.

Risk Category	LDL Goal	LDL Level to Start TLC	LDL to Consider Drug Therapy	Non-HDL (Total-HDL) Goal for Step 8
CHD or CHD 10 yr risk >20%	<100 mg/dl	≥100 mg/dl	≥130 mg/dl *	≥130 mg/dl
2 or more risk factors (10-20% 10 yr risk)	<130 mg/dl	≥130 mg/dl	**10-20% 10 yr risk:** ≥ 130 **<10% 10 yr risk:** ≥ 160	≥160 mg/dl
0-1 risk Factors (usually <10% 10 yr risk)	<160 mg/dl	≥160 mg/dl	≥ 190	≥190 mg/dl

Step 6: Initiate therapeutic lifestyle changes: Weight loss/management and increase physical activity.

Saturated fat <7% of calories, cholesterol < 200mg/day.

Increase soluble/viscous fiber (10-25g/day) and plant stanols/steroids (2g/day) as TLC options to lower LDL.

Step 7: Consider drug therapy with TLC for >20% 10 yr risk or after 3-6 months of TLC in other risk categories.

Drug Class: Meds	LDL	HDL	TG	Side Effects	Relative Contraindications	Absolute Contraindications
Statins: Lipitor, mevacor	-18-55%	+5-15%	-7-30%	Myopathy, LFT's	Active Liver disease	Certain other drugs
Bile Acid: Cholestyramine	-15-30%	+3-5%	0 or sl +	GI distress, constipation, altered drug absorption	Trig > 400mg/dl	Trig > 200mg/dl
Nicotinic acid: Niacin	-5-25%	+15-35%	-20-50%	Flushing, hyperglycemia, hyperuricemia, GI distress, LFT's	Diabetes, GI ulcers, hyperuricemia	Active liver disease Severe gout
Fibric acids: Gemfibrozil	-5-20%	+10-20%	-20-50%	Dyspepsia, gallstones, myopathy		Severe renal or liver

Step 8: Consider Metabolic Syndrome and Triglycerides (TG's). Primary treatment for both is weight management and increased physical activity.

If TG's 220-499mg/dl after LDL goal reached, consider: intensified LDL-lowering drug, niacin, or gemfibrozil to reach non-HDL goal above.

If TG's ≥500mg/dl, first lower TG's to prevent pancreatitis then: very low fat diet, intensify TLC's, niacin or gemfibrozil, and when TG's <500, treat LDL.

Step 9: Treatment of HDL < 40. Assess and treat LDL and non-HDL goals above. If TG's <200 with >20% 10 yr risk consider niacin or lopid.

1. ATP III Treatment Guidelines, NHLBI, NIH Publication #01-3305, 5/01

Effective: Oct. 2006

Physical Disability

Specify_____

Date

Appliances Prosthesis Assistance Devices				
Co-morbidity				
New Symptoms, Requests, etc.				
Exam				
Changes in Condition				
Activity/Education/ Diet/Housing/Other				

Name:_____
SID#:_____
DOB:_____

Special Needs_____

Date_____

Activity/Education/ Diet/Housing				

Name:_____
SID#:_____
DOB:_____

Monitoring

	Week 1	Week 2	Week 3	Week 4	Week 8	Week 12	Week 16	Week 20	Week 24
CBC and Platelet	X	X	X	X	X	X	X	X	X
Chem Panel		X		X	X	X	X	X	X
Pregnancy Test				X	X	X	X	X	X
TSH						X			X
Quantitative HCV-RNA									

Name_____
SID #_____
DOB_____

PATIENT CONSULT SHEET

INTAKE DATA / HISTORY: [date of admission]_____
[estimated release]_____

Date + _____ Weight: _____ Temp: _____ B/P: _____

RPR _____ Hepatitis ? _____ PPD _____

Community provider(s):_____

OTHER LABORATORY VALUES:

Hepatitis C Ab _____ Hepatitis A Ab _____

Hepatitis B core Ab _____ /surface Ab _____ surface Ag _____

Toxo titer _____ CMV titer _____

Attach Current: CBC, Chemistry Panel (fasting), CD4+, Viral Load (HIV-1 bDNA)

IMMUNIZATION / VACCINATIONS: (MANDATORY IF HEP C+_____

Hepatitis A #1 _____ #2 _____

Hepatitis B #1 _____ #2 _____ #3 _____

Tetanus _____/q 5 years Pneumovax /q 5 years _____

Influenza _____/q year

RPR follow-up _____ _____ _____ _____ _____

ANNUAL IMMUNIZATION:
Influenza See “Consent” Section in patient file

ANNUAL SCREENING:
PPD See “TB” Section in patient file

Name_____
SID #_____
DOB_____

ANTI-VIRAL TRACKING SHEET (P.1)

- = Protease Inhibitors; all others NRTI or NNRTI
- *IDV=indinivir=crixivan *NFV=nelfinavir=viracept *AMP=amprinovir=angerase
- *SQV=saquinavir=invirase *RTV=retonavir=norvir

ZDU=zidovudine=AZT
d4T=stavudine=zerit
CBV-combivir=AZT&Epivir
HDY=hydroxyurea=hydrea

ddl=diadnosine=videx
3TC=lamivudine=epivir
ABA=abacavir=ziagen

ddC=zalcitabine=hivid
EPV=elverenz=sustiva
NVP=nevirapine=viramune

Prior Medications:
Drug(s)

Dates:

_____ ___/___/___-___/___/___

_____ ___/___/___-___/___/___

_____ ___/___/___-___/___/___

Date:	Drug 1	Drug 2	Drug 3	CD4	Viral Load
__/__/__	_____	_____	_____	_____	_____
__/__/__	_____	_____	_____	_____	_____
__/__/__	_____	_____	_____	_____	_____
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__/__/__	_____	_____	_____	_____	_____
__/__/__	_____	_____	_____	_____	_____

Name_____
SID #_____
DOB_____

Date:	Drug 1	Drug 2	Drug 3	CD4	Viral Load
__/__/__	______	______	______	______	____________
__/__/__	______	______	______	______	____________
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__/__/__	______	______	______	______	____________

Name________________________

SID #________________________

DOB_________________________

Actual Form on Page 3
MATERIAL RISK NOTICE FORM

The 2003 Legislature made changes in the Intractable Pain Law (ORS 677.470-485) by requiring that the Material Risk Notice (PARQ) form be "provided and approved" by the Oregon Board of Medical Examiners and by removing the legal requirement for an "evaluation" (consultation) by a physician specializing in the "body part, system or organ" believed to be the source of the chronic pain.

The **Material Risk Notice** (MRN) supplied here has been created and approved by the Board. It is **not** intended to be a pain contract! This has been kept on one page and covers the required components of the law (ORS 677.485) and the Administrative Rule (OAR 847-015-0030). There are boxes for diagnosis, drugs to be used, goals, alternative treatments, and additional therapies.

The drugs that are to be used should be listed. If the opioids in the treatment plan are significantly changed, then the MRN should be reviewed with the patient and revised as needed.

The goal of significant reduction of pain is assumed and is printed on the form. In addition the patient should choose achievable simple goals. Achieving these goals should be used as a measure of the success of the treatment plan. If the patient is not having improved function, the treatment is not working.

The alternatives, if any, are to be listed in the appropriate box.

A list of additional therapies gives the provider a chance to make the patient understand that treatment for chronic intractable pain includes patient participation in his/her own care and serves as notification that such things as mental health evaluation, physical therapy, urine screens, etc. may be needed.

The bottom of the form gives the patient a chance to acknowledge that the provider has reviewed with the patient the information on the form to his/her satisfaction or the patient has requested more information and received that information to his/her satisfaction.

The provider's signature testifies that the provider has reviewed the form with the patient and witnessed the patient's signature.

This form may be used to comply with the requirement for a written and signed (by the patient) Material Risk Notice, or the attending physician may create a similar form that contains the same elements as this approved form as required under OAR 847-015-0030.

Even though the **legal requirement for a consultation** in all cases of chronic intractable pain has been **eliminated**, there will be many situations when the recognized standard of care in managing these patients will require such consultations. This is especially true for cases when the diagnosis or the best treatment is unclear, when the treatment is not accomplishing the expected goals, or when the patient's medical condition appears to be complex and very difficult to manage.

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 015 - BOARD OF MEDICAL EXAMINERS

847-015-0030
Written Notice Disclosing the Material Risks Associated with Prescribed or Administered Controlled Substances for the Treatment of "Intractable Pain."

(1) Controlled substances may be prescribed for long term treatment of "intractable pain", ORS 677.475 (1). The attending physician records must contain the attending physician's examination, diagnosis and any other supporting diagnostic evaluations and other therapeutic trials, including records from previous providers. If there is a consulting physician, written documentation of his/her corroborating findings, diagnosis and recommendations shall be included in the record.

(2) Before initiating treatment of "intractable pain" with controlled substances, the attending physician shall discuss with the patient the material risks associated with the prescribed or administered controlled substances. Following the discussion the patient may request further explanation prior to signing the material risks notice. Following completion of the discussion, the attending physician shall provide to the person and the person shall sign a written notice of the material risks associated with the prescribed or administered controlled substances to be prescribed, ORS 677.485.

(3) The material risk notice should include but not be limited to:

(a) The diagnosis;

(b) The controlled substance and/or group of controlled substances to be used;

(c) Anticipated therapeutic results;

(d) Alternatives to controlled substance therapy; and

(e) Potential side effects (if applicable):

(A) General;

(B) Central Nervous System;

(C) Gastrointestinal;

(D) Respiratory;

(E) Dermatologic, and

(F) Other.

(f) Allergy Potential;

(g) Interaction/Potentiation of other medications;

(h) Potential for dose escalation/tolerance;

(i) Withdrawal precautions;

(j) Potential for dependence and addiction;

(k) Potential for impairment of judgment and/or motor skills;

(l) Satisfaction with or desire for more explanation; and

(m) Patient signature (dated).

(4) The material risk consent form will be maintained as a permanent component of the patient record as shall documentation of long term follow-up to demonstrate the continued need for this form of therapy, ORS 677.480(1)(3). A dispensing record of the amount and dose of the prescribed or administered controlled substances shall be maintained as part of the patient record.

Select this text and Insert Clinic Name Here
MATERIAL RISK NOTICE

This will confirm that you, _____ have been diagnosed with the following
PATIENT NAME
condition(s) causing you chronic intractable pain: _____

I have recommended treating your condition with the following controlled substance(s):

1.	2.	3.

In addition to significant reduction in your pain, your personal goals from therapy are:

1.	2.	3.

Alternatives to this therapy are:

1.	2.	3.

Additional therapies that may be necessary to assist you in reaching your goals are:

1.	2.	3.

Notice of Risk: The use of controlled substances may be associated with certain **risks such as, but not limited to**:

1. **Central Nervous System**: Sleepiness, decreased mental ability, and confusion. Avoid alcohol while taking these medications and use care when driving and operating machinery. Your ability to make decisions may be impaired.
2. **Respiratory**: Depression (slowing) of respiration and the possibility of inducing bronchospasm (wheezing) causing difficulty in catching your breath or shortness of breath in susceptible individuals.
3. **Gastrointestinal**: Constipation is common and may be severe. Nausea and vomiting may occur as well.
4. **Dermatological**: Itching and rash.
5. **Urinary**: Urinary retention (difficulty urinating).
6. **Pregnancy**: Newborn may be dependent on opioids and suffer withdrawal symptoms after birth
7. **Drug Interactions** with or altering the effect of other medications cannot be reliably predicted.
8. **Tolerance**: Increasing doses of drug may be needed over time to achieve the same (pain relieving) effect.
9. **Physical dependence and withdrawal**: Physical dependence develops within 3-4 weeks in most patients receiving daily doses of these drugs. If your medications are abruptly stopped, symptoms of withdrawal may occur. These include nausea, vomiting, sweating, generalized malaise (flu-like symptoms), abdominal cramps, palpitations (abnormal heartbeats). All controlled substances (narcotics) need to be slowly weaned (tapered off) under the direction of your physician.
10. **Addiction (Abuse):** This refers to abnormal behavior directed towards acquiring or using drugs in a non-medically supervised manner. Patients with a history of alcohol and/or drug abuse are at increased risk for developing addiction.
11. **Allergic reactions**: Are possible with any medication. This usually occurs early after initiation of the medication. Most side effects are transient and can be controlled by continued therapy or the use of other medications

This confirms that we discussed and you understand the above. I asked you if you wanted a more detailed explanation of the proposed treatment, the alternatives and the material risks, and you (Initial one):

_____ were satisfied with that explanation and desired no further information

_____ requested and received, in substantial detail, further explanation of the treatment, alternatives and material risks

_____ DATE _____
PATIENT SIGNATURE
Explained by me and signed in my presence.

_____ DATE _____
PHYSICIAN SIGNATURE