

WAC 246-840-467 Patient evaluation and patient record. The advanced registered nurse practitioner shall evaluate and document the patient's health history and physical examination in the patient's health record prior to treating for chronic pain.

- (1) The patient's health history shall include:
 - (a) The nature and intensity of the pain;
 - (b) The effect of pain on physical and psychosocial function;
 - (c) Current and past treatments for pain, including medications and their efficacy;
 - (d) Review of any significant comorbidities;
 - (e) Any current or historical substance use disorder;
 - (f) Current medications and, as related to treatment of the pain, the efficacy of medications tried; and
 - (g) Medication allergies.
- (2) The patient evaluation prior to opioid prescribing must include:
 - (a) Appropriate physical examination;
 - (b) Consideration of the risks and benefits of chronic pain treatment for the patient;
 - (c) Medications the patient is taking including indication(s), type, dosage, quantity prescribed, and as related to treatment of the pain, efficacy of medications tried;
 - (d) Review of the prescription monitoring program (PMP) to identify any Schedule II-V medications or drugs of concern received by the patient in accordance with the provisions of WAC 246-840-4990;
 - (e) Any available diagnostic, therapeutic, and laboratory results;
 - (f) Use of a risk assessment tool and assignment of the patient to a high, moderate, or low risk category. The advanced registered nurse practitioner should use caution and shall monitor a patient more frequently when prescribing opioid analgesics to a patient identified as high risk;
 - (g) Any available consultations, particularly as related to the patient's pain;
 - (h) Pain related diagnosis, including documentation of the presence of one or more recognized indications for the use of pain medication;
 - (i) Written agreements, as described in WAC 246-840-475 for treatment between the patient and the advanced registered nurse practitioner;
 - (j) Patient counseling concerning risks, benefits, and alternatives to chronic opioid therapy;
 - (k) Treatment plan and objectives including:
 - (i) Documentation of any medication prescribed;
 - (ii) Biologic specimen testing ordered; and
 - (iii) Any labs or imaging ordered.
- (3) The health record must be maintained in an accessible manner, readily available for review, and contain documentation of requirements in subsections (1) and (2) of this section, and all other required components of the patient record, as set out in statute or rule.

[Statutory Authority: RCW 18.79.800 and 2017 c 297. WSR 18-20-086, § 246-840-467, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.79.400. WSR 11-10-064, § 246-840-467, filed 5/2/11, effective 7/1/11.]