Referral for concerns with opioid use - over-the-counter (OTC) analgesics containing codeine and/or prescription opioids

GP Name
GP Address

Date:

Pharmacist's name
Pharmacy name
Pharmacy Address
Pharmacy Phone number

Dear Dr. *(insert GPs name)*

RE: *(patient's name)*
(patient's address)

Discussed via phone: ☐

I have referred *(insert patient's name)* to you for review, following the identification of a potential issue with their use of opioids for pain.

☐ OTC opioids ☐ Prescription opioids

Potential issue:

☐ Inadequate pain management
☐ Suspected dependence on opioids
☐ Long-term or frequent use of opioids
☐ Other (please provide detail)

☐ Attached is a dispensing / MedsAssist history for this patient.

Comments:

Recommendations: I recommend you review *(insert patient's name)* pain management and/or dependence on these medications and if appropriate consider dependence management options including prescribing opioid replacement therapy (Suboxone or Methadone).

There is mentoring support available to aid in the management of these patients through the Western Victoria Primary Health Network, Opioid Management team **5222 0809 OR 0408 593 344.**

Attached is a management plan for you to complete and return to us to document outcomes and allow collaboration on the treatment of this patient. Please do not hesitate to contact me to discuss these issues further if required.

Yours Sincerely
(insert signature)

(insert printed name and relevant post nominal)

Management Plan

(Please tick all that apply)

RE: *(patient's name)*
(patient's address)

☐ I am happy for patient to continue on current medication regime (prescription supplied)

☐ Please do not supply any further opioids.

☐ I have reduced the patient's current prescription for opioids.

☐ I would like the patient to be on a regular pick-up for their opioids.

☐ I am starting opioid replacement therapy for this patient.

☐I have developed a pain/opioid management plan for this patient (plan attached)

☐ I have referred the patient to a specialist pain management service.

☐ I have referred the patient to a specialist drug and alcohol service.

☐ I have referred the patient to another health professional / health service.

☐ Other (please provide detail)

Signed:

Date:

PLEASE RETURN COMPLETED PLAN VIA REFERRAL NET OR THE PATIENT AS APPROPRIATE