WAC 246-817-919  Patient evaluation and patient record. The den-
tist shall evaluate and document the patient's health history and
physical examination in the patient record prior to treating for
chronic pain.

(1) History. The patient's health history must 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) Evaluation. The patient evaluation prior to opioid prescrib-
ing 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),
date, type, dosage, quantity prescribed, and, as related to treatment
of the pain, efficacy of medications tried;
(d) Review of the PMP to identify any Schedule II-V medications
or drugs of concern received by the patient in accordance with the
provisions of WAC 246-817-980;
(e) Any available diagnostic, therapeutic, and laboratory re-
sults;
(f) Use of a risk assessment tool and assignment of the patient
to a high, moderate or low-risk category;
(i) The dentist should use caution and shall monitor a patient
more frequently when prescribing opioid analgesics to a patient iden-
tified as high-risk;
(ii) "Risk assessment tool" means professionally developed, clin-
ically accepted questionnaires appropriate for identifying a patient's
level of risk for substance abuse or misuse.
(g) Any available consultations, particularly as related to the
patient's pain;
(h) Pain related diagnosis, including documentation of the pres-
ence of one or more recognized indications for the use of pain medi-
cation;
(i) Written agreements, as described in WAC 246-817-930, for
treatment between the patient and the dentist;
(j) Patient counseling concerning risks, benefits, and alterna-
tives to chronic opioid therapy; and
(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 require-
ments in subsections (1) and (2) of this section, as well as all other
required components of the patient record, as set out in statute or
rule.

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c
297. WSR 19-02-043, § 246-817-919, filed 12/26/18, effective 1/26/19.]