MISSOURI DEPARTMENT OF HEALTH & SENIOR SERVICES

Voluntary Non-Opioid Directive Form

Patient's Last Name	Patient's First Name	Middle Initial
Date of Birth (MM/DD/YYYY)		

Street or Physical Address		
City	State	Zip Code

Last Name of Guardian or Healthcare Proxy (if applicable)	First Name of Guardian or Healthcare Proxy (if applicable)	Middle Initial
Guardian or Healthcare Proxy Contact Primary Phone Number	Guardian or Healthcare Proxy Contact Secondary Phone Number	

PATIENT/GUARDIAN/HEALTHCARE PROXY STATEMENT (Signature & Date Required)

From completed by: ☐Patient ☐Guardian ☐Healthcare Proxy

This form certifies that the patient is declining the offer or administration of opioid medications. I understand the risks and benefits of this choice, and I hereby release the healthcare providers, medical practitioners, their administration and personnel, and the Missouri Department of Health and Senior Services from responsibility and liability for all consequences which may result from opioid abstinence under these circumstances. I further certify my understanding that I may effectively revoke this certification at any time, orally or in writing, for any reason.

Exceptions: I understand that this form **does not** pertain to opioids (1) prescribed for the treatment of opioid use disorder, or (2) administered directly by healthcare providers in the case of a medical emergency.

☐ **By checking this box, the patient declines the offer, supply, prescription, or other administration of any opioid (minus the exceptions noted above).**

☐ **By checking this box, I am revoking any previous Voluntary Non-Opioid Directive Form.**

Signature (Patient, Guardian, or Healthcare Proxy)	Date

Voluntary Non-Opioid Directive Information Sheet

The intent of the form is to help ensure that non-opioid options for pain management are considered during medical treatment. This option is a piece of Missouri's response to addressing the opioid crisis.

Benefits of this form:

- It allows a patient to proactively inform their healthcare provider that they do not wish to receive opioids due to the risks and side effects of this treatment.
- It helps prescribers and patients have a dialogue regarding the risks and/or personal or family history of substance use.
- It may prevent a prescriber from inadvertently offering certain controlled substances to those who could be adversely affected.
- It allows the patient to request an alternative to opioids, including but not limited to physical therapy, non-opioid pain medications, acupuncture, chiropractic care, meditation, and other multidisciplinary holistic approaches to treat pain and suffering.

Considerations for the healthcare provider team:

- This form serves as a helpful communication aid, allowing your patient to freely and explicitly express their preference on this health topic. This form provides information that is similar to identifying a patient's allergy or adverse medication reaction. It does not take the place of a detailed health history. Once completed, the provider team should incorporate the form into the patient's permanent medical record.
- Encourage the patient to share this form and their sentiments on the issue of opioids with each of their healthcare providers.

Considerations for the patient:

- If you are having a medical emergency, a healthcare provider may override this form.
- This form does not take the place of ongoing communication and collaboration with your healthcare provider.
- You can provide this form to each of your healthcare providers, including your pharmacist.
- If you change your mind about opioid use, carefully review this decision with your healthcare providers, loved ones, and others in your recovery network. If you choose to withdraw this form, you must complete a new form and check the box to revoke your previous form.