**Appendix A: Non-Opioid Directive Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH**  **VOLUNTARY NON-OPIOID DIRECTIVE (VNOD)** | | | | | | | | | DCPFORMDHCQ-17-1-668 | | |
| PATIENT’S LAST NAME | | |  | | | | | | | | | |
|  | | |  | | | | | | | | | |
| PATIENT’S FIRST NAME | | |  | | PATIENT’S MIDDLE NAME OR INITIAL   |  |  | | --- | --- | | PATIENT’S LAST NAME | AAAAAA | | | | | | | | |
|  | | |  | |  | | | | | | | |
| DATE OF BIRTH (MM/DD/YYYY) | |  | | | | | | |
|  | |  | | | | | | |
|  | | | | | | | | | | | | |
| STREET OR RESIDENTIAL ADDRESS | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| CITY | | | | | | STATE | | ZIP CODE (5 or 9 digits) | | | | |
|  | | | | | |  | |  | | | — |  |
|  | | | |
| LAST NAME OF GUARDIAN OR HEALTH CARE AGENT (If applicable) | | | |
|  | | | |
| FIRST NAME OF GUARDIAN OR HEALTH CARE AGENT | | | |  | | | MIDDLE NAME OR INITIAL   |  |  | | --- | --- | | PATIENT’S LAST NAME | aaaaaaaaaaaaa | | | | | | |
|  | | | |  | | |  | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT/GUARDIAN/HEALTH CARE AGENT STATEMENT (SIGNATURE AND DATE REQUIRED)** | | | | | | | | | | | | |  |
| I |  | | | | | | (patient  guardian health care agent) | | | | | |
| certify that I am refusing at my own insistence the offer or administration of any opioid medications including in an emergency situation where I am unable to speak for myself. I understand the risks and benefits of my refusal, and hereby release the health care provider(s) or emergency medical service, its administration and personnel, from any responsibility for all consequences, which may result by my abstinence under these circumstances. I further certify my understanding that I may effectively revoke this certification at any time orally or in writing.  I hereby direct that health care provider(s) or emergency medical service(s), their administration and personnel, comply with the Massachusetts Department of Public Health Voluntary Non-Opioid Directive regulations and guidance with regard to the above named patient. | | | | | | | | | | | | |
|  | | | | | | | | | |  | |  |
| Signature of Patient/Guardian/Health Care Agent | | | | | | | | | | Date |
|  | | | | | | | | | | | | | |
| **SIGNATURE AND DATES (ALWAYS REQUIRED)** | | | | | | | | | | | | | |
| I am a health care practitioner for the above named patient. I verify that the above named patient has a current and valid Voluntary Non-Opioid Directive (VNOD) | | | | | | | | | | | | | |
| issued on | |  | |  | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Signature of Health Care Practitioner | | | | | | | |  | | | | | |
| Print Name of Health Care Practitioner | | | Effective Date of VNOD certification | | | | |  | | | | | |
|  | | | | |  |  | | |  | |  | | |
| Address of Health Care Practitioner | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Telephone Number of Health Care Practitioner | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |

First Copy: To be kept by patient

Second Copy: To be kept in patient’s permanent medical record

**If the person completing this form is currently enrolled in substance use treatment,**

**appropriate consents must comply with HIPAA and 42 CFR Part 2.**