Appendix A: Non-Opioid Directive Form

DCPFORM
DHCQ-17-1-668

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

VOLUNTARY NON-OPIOID DIRECTIVE (VNOD)

PATIENT'S LAST NAME	
PATIENT'S FIRST NAME	PATIENT'S MIDDLE NAME OR INITIAL
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/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.