



Saskatchewan Registered  
Nurses Association  
2066 Retallack Street  
Regina, Saskatchewan  
S4T 7X5

**RN(NP) Practice Assessment  
Maintenance Prescriber for Opioid Use Disorder (OUD) and/or  
Methadone for Pain Management**

**Reference Documents**

Current SRNA *Registered Nurse (Nurse Practitioner) Practice Standards, Council Policy 3.19 - RN(NP) Prescribing Drug Therapeutics for OUD, and Council Policy 3.20 - RN(NP) Prescribing Methadone for Pain Management.*

First Name \_\_\_\_\_ Middle Initial \_\_\_\_ Last Name \_\_\_\_\_

Date of Birth (DD/MMM/YYYY) \_\_\_\_\_ RN(NP) Licence # \_\_\_\_\_

Primary Facility of Practice: \_\_\_\_\_

I am requesting prescribing approval for: OUD \_\_\_\_ Methadone for Pain \_\_\_\_ Both \_\_\_\_

All sections require a response unless otherwise stated. Send completed form to [regulation@srna.org](mailto:regulation@srna.org) as part of your application for prescribing drug therapeutics for OUD and/or methadone for pain management.

**Standard 1 - Professional Responsibility and Accountability**

1.1 Identify the strategies to support your clinical judgement and reasoning.

1.2 Identify your plan to participate in continuing education opportunities.

**Standard 2 - Knowledge-based Practice**

2.1 List the current best practice evidence you use to support your clinical decisions.

2.2 Describe the multidisciplinary team that you will work with.

**Standard 3 - Ethical Practice**

3.1 What strategies will you implement to incorporate culturally appropriate and trauma informed care into your practice?

3.2 What strategies will you implement to prevent prescription fraud or diversion?

**Standard 4 – Service to the Public**

	YES	NO
4.1 Do you have employer support to prescribe?	<input type="checkbox"/>	<input type="checkbox"/>
4.2 Does your organization have policies to support best practice and standards of care?	<input type="checkbox"/>	<input type="checkbox"/>
4.3 Will your clients have access to after hours care and continuity of care through the multidisciplinary team? If no, explain:	<input type="checkbox"/>	<input type="checkbox"/>

4.4 How will you prioritize prescribing for clients at most risk or special situations?

**Standard 5 – Self-Regulation**

5.1 Explain how prescribing for OUD and/or methadone for pain management meets *Council Policy 3.21 Common Medical Disorders*.

**Standard 6 – Therapeutic Management**

	YES	NO
6.1 Will you utilize standardized documentation for all client encounters? If no, explain:	<input type="checkbox"/>	<input type="checkbox"/>
6.2 What information will you require when accepting a referral?		
6.3 What strategies will you implement to ensure you collect the best possible client health information and medication history?		

6.4 What diagnostic and laboratory testing strategies will you incorporate to inform safe prescribing?

6.5 Who is your initiating prescriber support?

6.6 What practice challenges do you anticipate?

Email signed form to [regulation@srna.org](mailto:regulation@srna.org)

I certify that the information I have provided on this form is true and correct and acknowledge that my application for prescribing drug therapeutics for OUD and/or methadone for pain management may be refused or my approval could be suspended if I have provided any inaccurate information.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_