Gulf Coast Pain Specialists

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PAIN MANAGEMENT TREATMENT CONSENT

The following information is meant to help clarify your understanding of, and aid you in, giving consent for your procedure with Gulf Coast Pain Specialists.

1. The nature and purpose of the treatment plan, possible alternative treatments, risks, and possible complications will be explained to you by the physicians at Gulf Coast Pain Specialists. Assure that all questions and concerns are addressed prior to any procedures.

2. I understand that during the course of my treatment unforeseen conditions may necessitate an extension of the original treatment plan. I, therefore, authorize my physician or his designee perform such treatments as are deemed necessary in the exercise of his/her professional judgment.

3. I understand that Gulf Coast Pain Specialists is a physician training program affiliated with the University of Florida College of Medicine Department of Anesthesiology Pain Fellowship Division.

4. I consent to the admittance and involvement of qualified personnel, such as doctors, nurses or technicians, for the purpose of medical education as deemed necessary by your physician at Gulf Coast Pain Specialists.

5. I consent to be tested for AIDS (HIV infection) only in the event a health care worker receives my blood or body fluids to an open wound or his/her mucous membranes or receives a needle stick during the course of my treatments at Gulf Coast Pain Specialists.

I confirm by my signature that I have read and fully understand the above Pain Management Treatment Consent.

(Patient) (Witness)

(Date) (Time)

Gulf Coast Pain Specialists

Long-term Controlled Substances Therapy for Chronic Pain Consent/Policy

The purpose of this policy is to protect your access to controlled substances and to protect our ability to prescribe for you. This additionally will be your consent to the administration of addictive medications with potential side effects.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

I understand that the common side effects of opioid therapy include constipation, nausea, sweating, and itchiness of the skin. Drowsiness may occur when starting opioid therapy or when increasing the dosage. I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness disappears.

I understand that dangerous side effects can occur if these medications are taken with other medications or mixed with alcohol. I agree not to take any unauthorized medications or mix pain medications with alcohol intake.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician at GCPS to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. All controlled substances must come from your physician at GCPS or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)

2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

   _____ _____

   phone:_____

3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.

5. You may not share, sell, or otherwise permit others to have access to these medications.

6. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder, discontinuation of therapy with controlled substance and discharge from Gulf Coast Pain Specialists.

7. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.

8. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

9. Medications generally will not be replaced if they are not lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.

10. Early refills will generally not be given. These medications should not be stopped abruptly, as an abstinence syndrome will likely develop. Therefore, take all medications as prescribed to avoid early refill issues.

11. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.

12. Refills, in general, will not be called in after office hours or on weekends.

13. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

14. Renewals are contingent on keeping scheduled appointments, completing recommended treatment programs such as smoking cessation, weight loss, and reconditioning programs.

15. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.

16. The risks and potential benefits of these therapies will be discussed by your physician. You will ask questions and seek any additional information from your physician and pharmacist as needed. You will obtain medication insert from the pharmacist for a complete list of side effects, precautions and drug interactions for all medications taken.

17. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician, referral for further specialty assessment, and discharge from Gulf Coast Pain Specialists.

18. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

_____ _____

Patient Signature Patient Name (Printed)

_____

Date

Gulf Coast Pain Specialists

PATIENT INTAKE FORM

NAME:_____ TODAY'S DATE:_____
FIRST MIDDLE LAST

AGE:_____RACE:_____

D.O.B.:_____

1. **NAME OF DOCTOR (PERSON) THAT REFERRED YOU TO OUR PRACTICE:**
   _____
2. **NAME OF YOUR PRIMARY CARE DOCTOR:**
   _____
3. **WHY ARE YOU SEEING THE DOCTOR TODAY?** (WHERE DO YOU HURT?)
   _____
   _____
   _____
4. **ONSET OF SYMPTOMS: HOW LONG HAVE YOU HAD THIS PROBLEM?**_____
5. **WHAT CUASED YOUR PROBLEM?** □INJURY □MOTOR VEHICLE ACCIDENT □WORK ACCIDENT □UNKNOWN
   EXPLAIN:_____
   _____
6. **NURSE'S HISTORY:**_____
   _____
   _____
   _____
   _____
   _____
   _____
7. **(A) HAVE YOU EVER BEEN TREATED FOR THE SAME SYMPTOMS BEFORE THIS STARTED?** …… □Y □N
   IF YES, WHEN? _____
   DIAGNOSIS:_____
   (B) DID YOU FULLY RECOVER? …… □Y □N IF YES, WHEN?_____
8. **ARE YOU PRESENTLY BEING TREATED BY A DOCTOR FOR YOUR INJURIES?** …… □Y □N
   IF YES, NAME OF DOCTOR: _____ DATE LAST SEEN: _____
9. **CHECK ALL THAT APPLY TO YOUR SYMPTOMS:**

PAIN QUALITY:	**INCREASE PAIN:**	**DECREASE PAIN:**	**ASSOCIATED SYMPTOMS:**	
□ sharp	□ sitting	□ sitting	□ weakness	□ insomnia
□ aching	□ lying down	□ lying down	□ numbness	□ pain wakes at night
□ burning	□ walking	□ walking	□ tingling	□ sexual dysfunction

□ shooting □ bending □ bending □ fever □ other_____

□ constant □ weather □ weather □ weight loss _____

□ intermittent □ coughing/sneezing □ bowel/bladder problems

10. PREVIOUS TREATMENTS FOR PAIN:

	TREATMENT	HELPFUL?	CURRENTLY ONGOING	COMMENTS
Ten Unit?	□ Y □ N	□ Y □ N	□ Y □ N	
Physical/Occupational Therapy?	□ Y □ N	□ Y □ N	□ Y □ N	
Psychological Evaluation? WHO:_____	□ Y □ N	□ Y □ N	□ Y □ N	
Chiropractic Treatment? WHO:_____	□ Y □ N	□ Y □ N	□ Y □ N	
Nerve Blocks? WHO:_____	□ Y □ N	□ Y □ N	□ Y □ N	
Surgeries? Type:_____	□ Y □ N	□ Y □ N		

11. DIAGNOSTIC INFORMATION:

Radiologic Studies		PART OF BODY	DATE/WHEN	WHERE	RESULTS
X-Rays	□ Y □ N	_____	_____	_____	_____
MRI	□ Y □ N	_____	_____	_____	_____
CT Scan	□ Y □ N	_____	_____	_____	_____
EMG (Nerve Study)	□ Y □ N	_____	_____	_____	_____
Bone Scan	□ Y □ N	_____	_____	_____	_____
Myelogram	□ Y □ N	_____	_____	_____	_____
Other	□ Y □ N	_____	_____	_____	_____

12. PAIN DIAGRAM

MARK AS FOLLOWS: A-ACHE B-BURNING N-NUMBNESS P-PINS & NEEDLES S-STABBING O-OTHER (Describe):

13. PAIN SCALE (MARK WITH AN X ALONG THE BAR TO INDICATE DEGREE)

(A) HOW DO YOU RATE YOUR PAIN NOW?

_____

0 5 10

None Moderate Unbearable

14. MEDICATIONS: □ NONE □ I PRESENTLY TAKE THE FOLLOWING:

NAME OF MEDICATION AMOUNT PER DAY REASON LAST DOSE TAKEN

_____

_____

_____

_____

_____

15. ALLERGIES: IVP Dye: □ Y □ N Shellfish: □ Y □ N Morphine: □ Y □ N Aspirin: □ Y □ N

Steroids: □ Y □ N Novocaine: □ Y □ N Valium: □ Y □ N Other: □ Y □ N

WHAT TYPE OF REACTION?

_____

_____

_____

16. PAST MEDICAL HISTORY:

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

CNS **CARDIOVASCULAR** **RESPIRATORY** **METABOLIC**

□ Y □ N Cerabral Aneurysm □ Y □ N Hypertension □ Y □ N Asthma □ Y □ N Liver Disease

□ Y □ N Stroke □ Y □ N Valve Disease □ Y □ N Emphysema □ Y □ N Diabetes/Type_____

□ Y □ N Brain Tumor □ Y □ N Heart Attack □ Y □ N Bronchitis □ Y □ N Thyroid

□ Y □ N Seizure Disorder Date_____ □ Y □ N Bleeding Disorder

□ Y □ N Neuropathy □ Y □ N Irregular Heartbeat **PSYCHIATRIC**

Type:_____

□ Y □ N Pacemaker □ Y □ N Depression □ Y □ N Overweight

GASTROINTESTINAL □ Y □ N Anxiety

□ Y □ N Hiatal Hernia **GENITOURINARY** **INFECTIOUS**

□ Y □ N Ulcer □ Y □ N Kidney Disease **BONE/MUSCLE** □ Y □ N Hepatitis-Type_____

Other:_____ □ Y □ N **Are you now** □ Y □ N Arthritis □ Y □ N AIDS

pregnant? □ Y □ N Fibromyalgia □ Y □ N Cancer

Other:_____

Type:_____

Treatment:_____

17. REVIEW OF SYSTEMS

CONSTITUTIONAL:

□ Y □ N Fever □ Y □ N Weight Loss □ Y □ N Insomnia

MUSCULOSKELETAL:

□ Y □ N Joint Pain □ Y □ N Joint Swelling

ENT:

□ Y □ N Sinus Headaches

OPTHALMOLOGY:

□ Y □ N Loss of Vision □ Y □ N Blurring of Vision

RESPIRATORY:

□ Y □ N Shortness of Breath □ Y □ N Cough

CARDIOLOGY:

□ Y □ N Chest Pain □ Y □ N Congestive Heart Failure □ Y □ N Leg Swelling

GASTROGENTEROLOGY:

□ Y □ N Heartburn □ Y □ N Vomiting

NEUROLOGY:

□ Y □ N Headache □ Y □ N Dizziness □ Y □ N Seiuzures

UROLOGY:

□ Y □ N Frequent Urination □ Y □ N Recurrent UTI

ENDOCRINOLOGY:

□ Y □ N Diabetes □ Y □ N Osteoporosis

PSYCHOLOGY:

□ Y □ N Depression □ Y □ N Sleep disturbances □ Y □ N High Stress Level

18. SURGICAL HISTORY:

SURGERIES: LIST TYPE & DATE

_____

_____

_____

_____

19. FAMILY HISTORY

HAVE ANY OF YOUR FAMILY HAD THE FOLLOWING:

□ Y □ N Cancer. If Yes, who _____ □ Y □ N Alcoholism. If Yes, who_____
□ Y □ N Diabetes. If Yes, who _____ □ Y □ N Drug Abuse. If Yes, who_____
□ Y □ N Heart Disease. If Yes, who_____ □ Y □ N Suicide. If Yes, who_____
□ Y □ N Psychiatric Disorders. If Yes, who_____ What type?_____

20. SOCIAL HISTORY
MARITAL STATUS: □MARRIED □SINGLE □WIDOWED □DIVORCED
CHILDREN: □ UNEMPLOYED □ RETIRED How Many? _____
EDUCATION: (Circle highest level attended)
GRADE SCHOOL JUNIOR HIGH SCHOOL 7 8 9 HIGH SCHOOL 10 11 12
COLLEGE 1 2 3 4 GRADUATE SCHOOL
HABITS:
SMOKING: □ NONE PACKS PER DAY:_____ HOW MANY YEARS? _____
ALCOHOL: □ NEVER □ SOCIAL □ LIGHT □ MODERATE □ HEAVY
DRUGS: □ NEVER □ OCCASIONALLY □ FREQUENTLY WHAT KIND?_____
INTRAVEINOUS DRUG USE? □ Y □ N

21. EMPLOYMENT: (IF INJURY IS WORK RELATED, COMPLETE WORK ACCIDENT SECTION)
OCCUPATION AT TIME OF INJURY (ONSET): _____ _____ □ UNEMPLOYED □ RETIRED
CURRENT OCCUPATION: _____ □ UNEMPLOYED □ RETIRED
TYPE OF WORK: □ OFFICE/CLERICAL □ LIGHT LABOR □ MODERATE LABOR □ HEAVY LABOR
IF UNEMPLOYED, ARE YOU RECEIVING ANY OF THE FOLLOWING:
□ DISABILITY INCOME □WORKMAN'S COMP □RETIREMENT
WHEN DID YOU LAST WORK?
_____
WHAT TYPE OF WORK DO/DID YOU DO?_____
NUMBER OF HOURS WORKED PER WEEK?_____
IF ON DISABILITY, WHO PUT YOU ON IT?_____
HAVE YOU EVER BEEN PUT ON WORK RESTRICTIONS? □ Y □ N
IF YES, WHAT ARE THEY?_____

22. DOCTOR'S NOTES:_____
_____
_____

_____

_____

_____

ALL OF THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE:_____

DATE:_____