Trinity Pain Management
Nader Said, MD.
8115 State Rd. 54, New Port Richey, FL 34655

To help us understand your problem, please complete ALL QUESTIONS on ALL of the attached forms.

Date _____

Name _____ Age _____ Date of Birth _____

Height: _____ Weight: _____ Who referred you to us? _____

Family/Primary Care Physician _____ Phone _____

Which part of your body hurts the most? _____

How long have you had this pain? _____

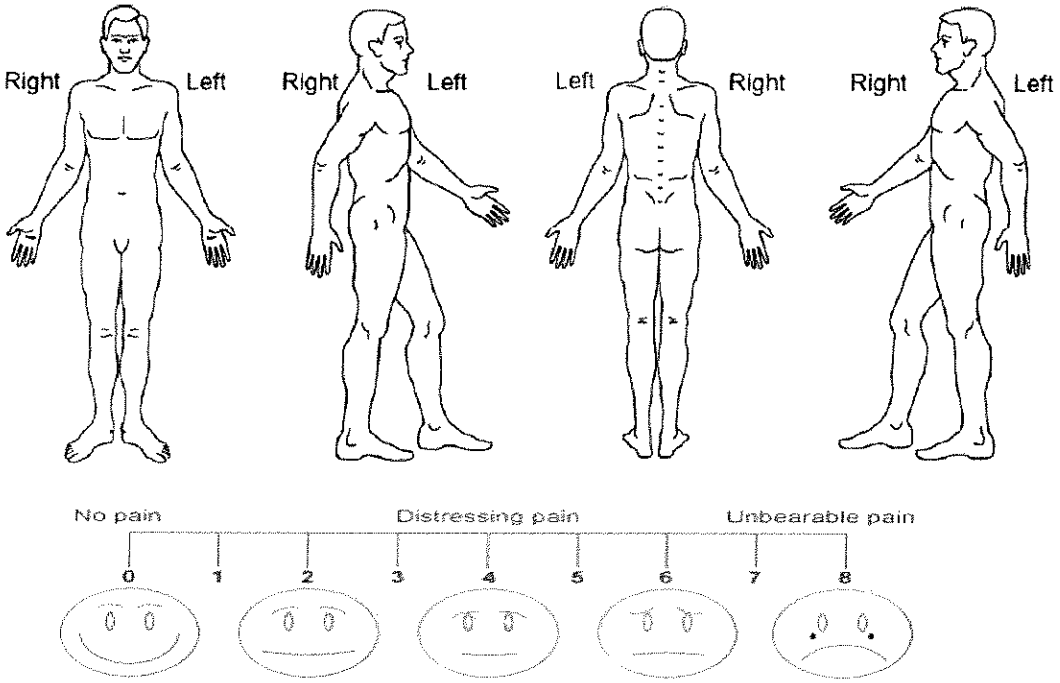
Was pain caused from MVA/Trauma: Yes - No Illness: Yes – No Unknown Cause: Yes – No

If MVA/Trauma please explain and give dates: _____

Are you involved in any litigation or lawsuit as a result of your pain? ☐ Yes ☐ No

Are you seeking Workers Compensation as a result of your pain? ☐ Yes ☐ No

On a scale of 0 to 10, "0" being no pain and "10" being the worst pain imaginable, circle the number that describes **your level of pain:**



Shade in areas below where you have pain and check **ALL** the words that best describe your pain:

☐ Aching	☐ Shooting	☐ Tingling	☐ Radiating	☐ Tightness
☐ Dullness	☐ Stinging	☐ Burning	☐ Stabbing	☐ Numbness
☐ Excruciating	☐ Coldness	☐ Sharpness		
☐ Constant	☐ Frequent	☐ Intermittent	☐ Occasional	

Patient Name: _____ **Date:** _____

Please indicate the factors or activities of daily living that increase or decrease your pain:

Factors	Increase	Decrease	No Effect		Factors	Increase	Decrease	No Effect
Weather Change					Pressure			
Heat					Sexual Activity			
Cold					Bowel movement			
Physical Activity					Bright light/noise			
Posture					Sneeze, cough			
Walking					Sitting			
Lying down					Sleep			
Appetite					Travel			
Occupation					Communication			
Other					Other			

Do you have any of the following?

Numbness/Tingling Yes No If yes, were? _____

Weakness Yes No If yes, were? _____

Bowel/ Bladder Incontinence Yes No If yes, were symptoms present before pain began? Yes No

Headache: Yes No

Pain site: _____ Nature of pain: _____ Duration of pain: _____

Pain triggers: Tobacco Alcohol Exercise Noise Sex Weather Menstrual Cycle Other

Pain symptoms: Nausea/Vomiting Photophobia/ Phonophobia Myosis/Ptosis Lacrimal/Nasal congest

Pain relievers: Quiet Dark Room Other: _____

Please list any physicians you have seen for your pain:

Name	Recommendation	Specialty

Please check any of the following treatments you have received for this pain problem:

	Approximate Date/Details	Improved Pain Yes	No
Nerve Blocks			
Physical Therapy			
Acupuncture			
Chiropractor			
Psychiatrist/Psychologist			
Surgery			
Other			

Patient Name: _____ **Date:** _____

Do you have any allergies to medication or food? Yes No

Please list your allergies and the reaction below:

Medication	Reaction	Medication	Reaction
1.		4.	
2.		5.	
3.		6.	

Please list all medications you are currently taking:

1.	4.	7.	10.
2.	5.	8.	11.
3.	6.	9.	12.

Are you taking narcotics from any physician? Yes No

Have you ever taken or been given:	**Yes**	**No**	**Adverse Reaction?**
Anticoagulants, Blood-thinners, Coumadin, Plavix, Pletal			_____
Cortisone or Steroids			_____

Social History:

Do you currently work? ☐ Yes ☐ No What is/was your occupation _____

Marital status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed Number of children _____

Education _____

Dominate Hand: ☐ Right ☐ Left Is there any possibility that you are pregnant? ☐ Yes ☐ No

Do you smoke? Circle all that apply: Never Smoke Former Smoker Current smoke: Cigarettes Cigars

Do you Drink Alcohol? Circle all that apply: Beer Wine Liquor Light Heavy Occasionally Social

Do you use caffeine? Circle all that apply: Coffee Tea Carbonated Drink Energy Drinks

Do you use any of the followings: Cocaine Marijuana Heroin Methamphetamine Club Drugs _____

Other _____

If yes, the last time used: _____

Family History:

Describe current health, age, cause of death, illness, diabetes, cancer, hypertension, etc.

	Age	Living Yes	Living No	Medical History or Cause of Death
Father				
Mother				
Brother				
Sister				

Have you been tested for HIV Virus? ☐ Yes ☐ No Date _____ ☐ Positive ☐ Negative

Have you been diagnosed with any of the following? Hepatitis Yes No

Any sexually transmitted disease Yes No

Patient Name: _____ **Date:** _____

Past Medical History: **Please list past or current medical problems:**

Heart Disease	Lung Disease	Diabetes	Stroke	Herpes (Shingles)
Hypertension	Kidney Problems	Liver Disease	Seizures	Open Wound
Migraines	Thyroid Disease	Depression/Anxiety	GERD/Ulcer	Current Infection
Other				

Have you ever been diagnosed with cancer? Yes No If yes, what type(s)? _____

Currently receiving treatment? Yes No If yes, type(s) of treatment? _____

Please List any Surgeries:

Surgery/Date	Surgery/Date
1.	5.
2.	6.
3.	7.
4.	8.

CAGE:

Have you ever felt the need to cut down on your drinking or drug use? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking or your drug use? ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking or your drug use? ☐ Yes ☐ No

Have you ever needed an eye opener the first thing in the morning to steady your nerves or get rid of a hangover?

☐ Yes ☐ No

Are you currently in a ***Relationship*** in which you are being hurt, threatened, or made to feel afraid? ☐ Yes ☐ No

OPIOID RISK TOOL (ORT):		Male	Female
Family H/O Abusing	Alcohol	3	1
	Illegal Drugs	3	2
	Prescription Drugs	4	4
Personal H/O Abusing	Alcohol	3	3
	Illegal Drugs	4	4
	Prescription Drugs	5	5
Menthal Health DX of ADD, OCD, BiPolar, Schizophrenia		2	2
	Depression	1	1
Age 16 to 45 Years Old		1	1
H/O Preadolescence Sexual Abuse		0	3
	TOTAL	_____	_____

Have you had or do you have *Suicidal* thoughts? ☐ Yes ☐ No ☐ Any Plans ☐ Number of Attempts

Treating Psychiatrist/Therapist's Name _____

Phone Number _____

Patient Name:_____ **Date:** _____

MAST

1.	Do you feel you are a normal drinker?	YES	0	NO	2
2.	Do friends or relatives think you are a normal drinker?	YES	0	NO	2
3.	Have you ever attended a meeting of Alcoholics Anonymous (AA)	YES	5	NO	0
4.	Have you ever lost friends or girlfriends/boyfriends because of drinking?	YES	2	NO	0
5.	Have you ever gotten into trouble at work because of drinking?	YES	2	NO	0
6.	Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?	YES	2	NO	0
7.	Have you ever had delirium tremens (DTs), severe shaking, heard voices, or seen things that weren't there after heavy drinking?	YES	2	NO	0
8.	Have you ever gone to anyone for help about your drinking?	YES	5	NO	0
9.	Have you ever been in a hospital because of drinking?	YES	5	NO	0
10.	Have you ever been arrested for drunk driving or driving after drinking?	YES	2	NO	0
	TOTAL	YES	_____	NO	_____

COMM-9 DURING THE LAST 30 DAYS HOW OFTEN HAVE YOU :

1- had trouble thinking clearly or had memory problem----------	0	1	2	3	4
2- had people complaining that you're not completing necessary tasks ----------	0	1	2	3	4
3- seriously thought about hurting yourself ----------	0	1	2	3	4
4- had trouble controlling your anger (screaming)----------	0	1	2	3	4
5- had to visit the emergency room----------	0	1	2	3	4
6- had to contact our office before your scheduled appointment----------	0	1	2	3	4
7- had to go to someone other than your prescribing doctor to get pain relief medications(including street sources)----------	0	1	2	3	4
8- had you taken your pain medication differently from how they are prescribed----------	0	1	2	3	4
9- used pain medication for other symptoms other than pain (help you sleep , improve your mood , relief a stress)----------	0	1	2	3	4
10- had to take pain medication from someone else----------	0	1	2	3	4
11- been worried about how you're handling your medication----------	0	1	2	3	4

0 = Never , 1 = Rarely , 2= Sometimes , 3= Often , 4= Very Often

Patient Health Questionaire PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Not at all Several days More than half the days Nearly every day (use "n" to indicate your answer) 0 1 2 3.

1-Little interest or pleasure in doing things	0 1 2 3.
2-Feeling down, depressed, or hopeless	0 1 2 3.
3-Trouble falling or staying asleep, or sleeping too much	0 1 2 3.
4-Feeling tired or having little energy	0 1 2 3.
5-Poor appetite or overeating	0 1 2 3
6-Feeling bad about yourself or that you are a failure or have let yourself or your family down.	0 1 2 3
7-Trouble concentrating on things, such as reading the newspaper or watching television	0 1 2 3
8-Moving or speaking so slowly that other people could have noticed. Or the opposite being so figety or restless that you have been moving around a lot more than usual	0 1 2 3
9-Thoughts that you would be better off dead, or of hurting yourself	0 1 2 3

TOTAL_____

Patient Name: _____ **Date:** _____

Review Of Systems:

Please check if you have or have ever had any of the following:

Constitutional	Respiratory	Cardiovascular		Gastrointestinal	
Chills	Bronchitis	Chest pain	Recent EKG	Abdominal Pain	Diarrhea
Fever	Tuberculosis	High Blood Pressure	Recent Heart Test (not EKG)	Change in stool color	Gallbladder Disease
Weight loss	Cough	Palpitation	Rheumatic Fever	Decreased Appetite	Hepatitis
Weight Gain	Pleurisy	Swelling of Leg	Ulcer on Legs	Hemorrhoids	Rectal Bleeding
Weakness	Short of Breath	Varicose Veins	Other	Jaundice	Constipation
Fatigue	COPD/ Asthma	Heart Murmur	Change in Bowel Control	Nausea /vomiting	Heartburn
Declined Health	Sputum	Heart Attack	Change in Bladder Control	Swallowing Problem	Liver Disease
		Thrombophlebitis		Change in Frequency of BM	Vomiting Blood

Musculoskeletal	Psychiatric	Neurological	Endocrine	Hematologic/Immunologic
Arthritis	Behavioral Change	Blackouts / Fainting	Cold Intolerance	Anemia
Gout	Disturbing Thoughts	Loss of consciousness	Goiter	Easy Bruisability
Muscle Cramps	Memory Loss	Tingling /Burning	Excessive Urination	Swollen Glands
Restricted Motion	Psychiatric Disorders	Head Injury	Heat Intolerance	Bleeding Easily
Back Problem	Depression	Speech disorders	Sweats	Lumps
Joint Pain	Anxiety	Tremors	Increased Thirst	Transfusion reaction
Muscle Stiffness	Excessive Stress	Dizziness	Thyroid Trouble	Blood Clots
Weakness	Mood Changes	Headaches	Weight gain / loss	Radiation Exposure
Deformities		Strokes		
Joint Stiffness		Unsteady gait		
Paralysis				

Genitourinary

Urinary	Male Genitalia	Female Genitalia	
Awakening to Urinate	Discharge	Birth control	Change in Periods - Duration
Burning	Impotence	Change in Periods - Flow	DES Exposure
Flank Pain	Prostate problems	Difficult Pregnancy	Fertility problems
Infections	venereal disease	Hernias	Lesions
Stones	Fertility Problems	Menopause	Pain on Intercourse
Urine Odor	Lesions	Postmenopausal Bleeding	Recent Pregnancy
Bed-Wetting	Scrotal Masses	Sexual Problems	
Difficulty Starting Stream	Hernias	Bleeding Between Periods	
Pain on Urination	Pain	Change in Periods - Interval	
Urgency	Sexual Problems	Discharge	
Blood in Urine		Itching	
Excessive Urination		Menstrual pain	
Incontinence		Recent Pap Smear	
Retention		Venereal Disease	

TRINITY PAIN MANAGEMENT
8115 SR 54
NEW PORT RICHEY, FL 34655
727-376-6111

Your procedure is scheduled for: _____

Cervical Epidural Steroid Injection Lumbar Epidural Steroid Injection Facet Block Radiofrequency

NO ASPIRIN OR BLOOD THINNING PRODUCTS for 5 days prior to your injection unless otherwise advised by your physician.
TAKE YOUR REGULAR DAILY MEDICATIONS AS USUAL.
Our office called in **TWO XANAX 1.0 mg** pills for you. Bring them to the office with you on the procedure day.

BREAKFAST: light meal
HYGIENE: shower or bathe as usual. Do not wear any facial makeup.
CLOTHING: Wear a comfortable pair of pants and a loose fitting shirt. NO metal buttons.
You may wear your dentures, hearing aids, glasses or contact lenses, however, these items may be removed prior to the procedure, so please bring a case with you to protect them while at procedure.
Please leave **VALUABLES**, money and jewelry at home.
MEDICATIONS: if you have been given a prescription have it filled before your procedure and take as directed.
TRANSPORTATION: You will not be allowed to operate a motor vehicle for 24 hours if you decide to take Xanax. In that case you need to have a driver.

After the procedure:
Your pain may return, and possibly even worse in intensity. This may be due to irritation from the injection or soreness at the site of the injection, this should only be temporary. Muscle spasms or cramps may occur. If you are sore at the injecftion site, you may find the applying ice may help. You should continue your normal medications or pain medications if you need them.
Following a nerve injection you may experience unusual sensation. These should not alarm you. You may experience new tingling sensations, or your arm or leg may feel warmer or cooler.
Someone from the clinic will be calling you two days after you injection to follow up with you.

CALL US IF YOU EXPERIENCE FEVER, STIFF NECK, LOSS OF SENSATION IN YOUR ARM OR LEG, SWELLING IN THE AREA OF INJECTION, SEVERE HEADACHES, BLURRED VISION, UNUSUAL WEAKNESS, NAUSEA OR VOMITING, UNUSUAL OR SEVER CHEST PAIN.

IF YOU ARE UNABLE TO REACH DR. SAID FOR ANY OF THE ABOVE CONCERNS, CALL 911 FOR HELP OR GO TO THE NEAREST EMERGENCY ROOM FOR EVALUATION! BE SURE TO TAKE THIS PAPER WITH YOU.

Cancellation policy: You can call to cancel yous scheduled procedure no later than Friday preceding procedure of Tuesday. That will allow us to fill your slot with another patient.
Failure to do so will result in a Charge of $150 that you should pay before your following appointment.

Patient Name: _____ Date: _____

Signature: _____

Trinity Pain Management

Patient Acceptance of Financial Responsibility

As a courtesy to you, we will bill your primary and secondary insurance carrier(s) if you provide ALL necessary information. However, you are ultimately responsible for all charges for services rendered. In addition, your insurance company may require an authorization or precertification for certain procedures, services, drugs and supplies that may be provided to you.

We will contact your insurance company for authorization for services; however, it is ultimately your responsibility to understand what your insurance policy covers and assures that you have authorization for services. As Pain management Office Urine Drug Test is random but mandatory for each patient. There may be services that are NOT cover by Medicaid

- You must pay any co-payment and applicable deductible amounts at the time of service (unless other arrangements have been made with our office.)
- Co-payments or deductibles towards procedures are the patient's responsibility and must be paid prior to the procedure. If payment if not received prior to a scheduled procedure, it will be postponed.
- If you are not insured, or if the services provided are not covered by your insurance, you will be expected to provide payment in full for our services at the time they are rendered.

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filling your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan.

If your health plan denies any claim for any of these or other reasons, our office cannot be responsible for this. It is your responsibility as the patient to pay the denied amounts in full.

Workers Compensation Patients: We must have prior authorization to treat from either the employer or the insurance carrier agent. Should the employer or carrier subsequently deny validated workers compensation services, such charges will be the financial responsibility of the patient.

Please Print: First Last Date

I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered or approved by my insurance carrier.

NOTICE OF PRIVACY PRACTICES FOR

PROTECTED HEALTH INFORMATION

(HIPAA)

" This Notices Describes How Medical Information About You May Be Used And Disclosed And How You May Get Access To This Information". Please Review It Carefully!

We Safeguard Information about your health and person:

We collect information from you and store it in a medical record on a computer. Charts are secure and available only to designated staff and only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the computer records. Service technicians may have access to the computer, but only for service of computer operations.

Typical Uses and Disclosures of Medical Information:

We collect medical information from you. Within our office, we restrict the disclosure of this information to doctors, nurse, technicians and insurance and billing personnel. We may use your medical information for treatment and care, payment to insurers and for healthcare operations. Outside our office, we restrict the disclosure to those people, entities and agencies for who, you authorize disclosure such as other health care providers (doctors, nurses, and extended care facilities), insurance companies, billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- When required by law
- Public health activities (death, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors
- Organ and tissue donation
- Research, provided authorization is IRD-approved or privacy board-approved
- Emergencies or to avert serious threat to health or safety
- Specialized government functions (military, inmates)
- Worker's compensation, Disaster relief

  We will not use or disclose your medical information for any purpose not listed, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

  AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I have read the authorization for use and disclosure of protected health information. I understand that I have the right to inspect and/or obtain a copy of the protected health information to be used or disclosed as permitted under federal law or state law to the extent the state law provides greater access rights. Or refuse to sign this authorization.

  Name of the person or persons we may speak to regarding your health:

1- 2- PCP: 3- Mental health:

May we leave a message regarding an upcoming appointment on your answering machine: _____ yes, _____ No

Patient signature _____ Date _____

Signature of Legal Representative (if other than patient):_____

Relations to patient: _____Witness:_____

TRINITY PAIN MANAGEMENT OPIOIDS AGREEMENT

CDC Guideline for Prescribing Opioids for Chronic Pain Aug 22,2016: I will start low and up the dose slow if needed. Tapering opioids down in near future is always in the treatment plan. I would generally AVOID increasing narcotic dosage to more than 90 MME (Milligram Morphine Equivalents) / day

© 2013 American Academy of Pain Medicine - Approved February 2013 Prescription of Opioids for Chronic, Intractable Pain Is Appropriate when The Treatment Plan Is Reasonably Designed to The Risks Of Addiction, Tolerance, Diversion, Respiratory Depression And Other Adverse Effects.

The long-term use of pain medications such as opioids, benzodiazepines, and barbiturates is controversial. A valid prescription for pain medications does not imply their safety while operating automobile or heavy equipment.

Our plans for pain management include: Medications, Physical Therapy, Interventions (injections) and Referral for consult if needed. Psychiatric consultation is a common standard of care in pain mgmt. Statistics showed that more than 60% of chronic pain patients have mood and anxiety disorder which can lead to worsening of pain, Chronicity of pain, Negative thoughts about pain, and risk of Suicide. In such occasions, I might order a psychiatric consult for your own safety.

All controlled chronic pain mgmt. substances must come from Dr. Nader Said, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interaction or poor coordination of treatment.) Obtaining pain medications from multiple sources is illegal.

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.

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

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

These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.

Unannounced urine drug testing will be performed. Presence of unauthorized substances may prompt referral for assessment addictive disorder. The absence of prescribed medications may result in discharge from the practice.

We can call you Any Day to come for **Pill Count.** You will have 24 hours to be in the office during business hours for the count.
Medications **will not be replaced** if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen, you must complete a police report regarding the theft.

Early refills will not be given. All prescriptions are written for a 30-day period unless otherwise noted.

Please do not phone for prescriptions **after hours or on weekends.**

It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit of improved Functional Capacity and normal UDT, PDMP, and Pill Count

Tranquilizers (Benzodiazepines), Alcohol, and Central nervous system depressants increase the effect of Opioid and cause Cognitive impairment and increase the risk of fall and death.
One pharmacy and **One** physician to prescribe and monitor all opioid medications and adjunctive analgesics.

Discontinuation of Opioids prescribing may be warranted in cases of Aberrant behaviors like:
Urine test positive for opioids not prescribed by us, or street drugs like Marijuana, Alcohol, Cocaine, Amphetamine.
OR negative for the prescribed opioids on two occasions. OR Failure to deliver a urine sample when asked on two occasions.

Medication use: Addiction signs and yet refusing Addiction treatment or refusing Multimodal treatment. An overwhelming focus on opioids. 2 occasions of unauthorized dose escalation, 2 occasions of early medication renewals, or prescription problems (lost, stolen, missed medications). Selling, sharing, or giving your opioids medications to others
Behavior: Being Sedated, Intoxicated, Unkempt (Coming to the office in undershirts, Pajamas, Clothes or Grooming not clean or appropriate, or smelling bad), Aggressive or threatening behavior in the clinic. Disrupting waiting room peace, or disturbing other patients. Family members or anonymous calls expressed concern about your use of opioids. Intentional suicide attempt. Multiple phone calls to our office. 2 occasions of missing office appointments (visits or injections), and unscheduled office visits.
Functional capacity: Declining Activity levels at home or at work. No improvement in Functional Capacity, Continuing pain with the evidence of intolerable adverse effects
Healthcare services use: Physician Shopping (Narcotics prescribed by any other provider other than Dr. Said without informing our office). Repeated visits to emergency rooms for pain, Law accidents: Repeated Accidents, Arrests, or Investigations

Medications use in Elderly patients: American Geriatrics Society Panel on the Pharmacological Management of Persistent Pain in Older Persons. J Am Geriatric Soc. 2009;57(8):1331-1346.: Acetaminophen is recommended for initial and ongoing treatment of persistent musculoskeletal back pain in older patients. There is a strong recommendation against the use of Anti-inflammatories, and Celebrex inhibitors due to serious and life-threatening gastrointestinal bleeding and cardiovascular adverse events which has shifted attention to opioids for older patients. Tricyclic antidepressants can cause blurred vision, dry mouth, constipation, orthostatic hypotension, tachycardia, and urinary retention. Systemic Corticosteroids should only be used in pain from systemic inflammatory disease or metastatic bone pain.

On the other hand, controlled trials have established the efficacy of various Opioids in the treatment of persistent pain associated with musculoskeletal conditions, including osteoarthritis and low back pain, and in the management of several neuropathic pain conditions, such as diabetic peripheral neuropathy and post herpetic neuralgia.

Opioids are recommended for most elderly patients with moderate-to-severe pain, pain-related functional impairment, or diminished quality of life due to pain. No other alternatives that have better results are available for this patient at this time. Thorough evaluation indicated that patient will adhere to therapy. If opioids are warranted, Short acting opioids will be tried first, and around-the-clock dosing should be used to achieve steady-state in frequent or constant pain. Cognitive, Renal and Hepatic functions, Accountable adult, Falls, Poly pharmacy, Side effects, and Altered pharmaco-dynamics and pharmaco-kinetics are all addressed and evaluated. If extended-release/long-acting opioids are used, it is vital to anticipate, assess, and prevent breakthrough pain by adding short-acting or immediate-release opioid formulations.

Males Only: I am aware that the chronic use of opioids has been associated with low testosterone levels in males. This may affect mood, stamina, sexual desire and physical and sexual performance.

Females Only: If I plan to become pregnant or believe that I have become pregnant while taking this medication, I will immediately inform my Obstetrician and this office. I am aware that taking opioids while pregnant will cause the baby to be physically dependent on them at birth. I am aware that the use of opioids is not generally associated with risk of birth defects; however, birth defects can occur whether or not I am taking medication, and there is always a possibility that my child will have a birth defect.

Short Acting Opioids would be recommended for pain where alternative treatment options are inadequate to improve patient's FC, and QOL. No medical comorbidity contraindicate the use of SAO. No other alternatives that have better results are available for this patient at this time. Thorough evaluation indicated that patient will adhere to therapy.

Long Acting Opioids would be recommended for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate to improve patient's FC, and QOL. Short acting opioids were tried and failed to manage the pain adequately. No medical comorbidity contraindicates the use of LAO, no other alternatives that have better results are available for this patient at this time. Thorough evaluation indicated that patient will adhere to therapy.

Patient is not Opioids Naive. Patient is Opioid Tolerant when on Codeine 150 mg per day, Fentanyl Patch 25 mcg transdermal/day, Hydromorphone Oral 8 mg per day, Methadone 20 mg per day, Morphine 60 mg per day, or Oxycodone 30 mg per day

Risk factors for Opioids overdose are continually addressed: 1-Patient non-adherence to medications regimen. 2-Mental and Medical Health co-morbidities. 3-Co- administration of Central Nervous System depressants including Alcohol and Benzos. 4-Sleep disorders (sleep apnea). 5- Body Mass Index more than 30. 6- High Opioid Risk Tools and Current Opioid Misuse Measure scores. 7- Use of Illicit drugs (mgt. and Strategy for safe opioids use 2015 P21)

Risk mitigation: Naloxone for possible OD, and Clonidine patch for possible withdrawal symptoms from tapering down opioids might be prescribed.

Side Effects of Opioids: Sedation, Impaired both mental status, and motor ability, and increased risk of falls. Sexual dysfunction, Sleeping abnormalities, and aggravation of Sleep apnea. Depressed Respiration. Decreased Immunity, Nausea, Constipation, Urinary retention, Skin rash, and Sweating. Overuse or Overdose of opioids can cause Death. Heavy machinery or Driving is not allowed until sedation and drowsiness are cleared Opioids will show on police tests (as positive DUI) Opioids fall in Category C for pregnancy, with neonatal opioids withdrawal syndrome, congenital heart defects, tube defects, preterm delivery, and stillbirth.

Addiction: I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, losing control of using a drug, and a decreased quality of life. I am aware that the development of addiction is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

Dependence/Withdrawal Syndrome: I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome (runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling)

Tolerance: I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

Contraindications to any use of opioid analgesics include: Acute psychiatric instability, suicide risk, alcohol or substance use disorder, Diversion, True opioid allergy, Current medication use with potential for dangerous drug interactions, Respiratory instability, Prolonged QTc (≥500 msec.) (with methadone)

Co-morbidities: Opioids are titrated carefully in patients with Liver, Kidney, or Heart disease.

Urine Drug Testing and Pharmacy Drug Monitoring Program are mandatory during the period of opioids prescribing.

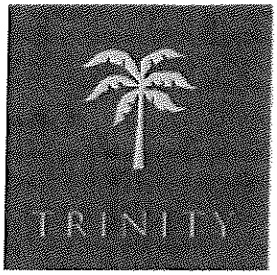
Opioids agreement: Patient understands that Non-compliance with this agreement and the above may lead to serious side effects including death. Noncompliance may lead to termination of our Opioids prescription and our service.

I understand with no understanding barriers and will adhere to the above guidelines.

Patient Signature: _____ Date: _____

Patient Name (Printed): _____

Dr Said Signature: _____



HEALTH CENTER

Trinity Pain Management
Office Policies

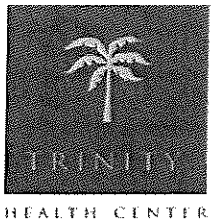
- First and Follow up visits are Only a Consultation Medications may not be prescribed at this visit. It is strictly up to the Doctor and office policy.
- $40 Short/long term disability or any other documentation, required Doctor Review or signature.
- You will be seen by **appointment only.**
- You may arrive **no** more than **15** minutes early.
- **No smoking in front of our office.**
- Call **24 hours in advance** of your scheduled appointment to cancel if needed. Under 24 hour notice, you will be charged a **$25.00 rescheduling fee**
- Call **48 hours in advance** of your **procedure** appointment to cancel if needed. Under 48 hour you will be charge $150.00 **cancellation fee** which must be paid **in addition** to your normal office visit fee, before you will be seen by the doctor.
- All future appointments will be cancelled until the fee is paid in full.
- Our office may communicate with you by e-mail, mail, phone and or voicemail.
- I agree to accept provided electronic copy of medical records.(patient portal)
- You must call between the hours of 9:00am and 4:30pm M – T and F 8:30am and 3:00pm and speak **to our staff.**
- Cell phone in the office or waiting room disrupts our doctor.

I read and fully agree with the office policy

If you under our contract you MUST report any injury or accident!!!

Signature: _____

Please Print: _____ Date: _____



*Patient Name*_____ *SS#*_____-_____-_____

*Phone#*_____ *Cell#*_____

*Address Street*_____

*City*_____ *State*_____ *Zip*_____

*E-mail Address*_____

Date of Birth _____/_____/_____ *Age* _____ *Sex M F Race*_____

*Height*_____ *Weight*_____ *Marital Status S M D W Other*_____

Spouse/Significant Other _____*Phone#* _____

Employer _____*Phone#* _____

Primary Physician _____*Phone#*_____

Fax# _____*Referring Physician*_____

Pharmacy _____*Phone#*_____

Primary Insurance _____ *Secondary Insurance* _____

Is this a Workman's Compensation Claim? YES NO If Yes Claim# _____

Date of Injury ____/____/____

*Is this a Motor Vehicle Accident Claim? YES NO If yes Clain#*_____

Date of Injury ____/____/____

Adjustor's name _____*Phone#*_____

Agreement: I understand I am totally responsible for all charges to my account. I understand that this office will file my insurance and that I am responsible for any amount not paid. If this account has to be collected by an attorney, I understand that I will be responsible for the attorney fees also. I authorize release of my medical information to my physicians and insurance carriers. I also authorize payment of benefits directly to my physicians.
*Signature*_____*Date*_____/_____/_____

I, _____*(please print) give permission for Trinity Pain Management to take an identification photograph to be maintained in my medical records. I understand that this picture will be used in a confidential manner related only to my personal care in the above named office.*

Patient Signature _____*Date* ____/____/_____