FMC Interventional Pain

New Patient Packet

Please have this packet completed by the time of your first appointment. If it is not completed, you will be asked to reschedule. The following documents and medications are needed at the time of your appointment to ensure the doctor can care for you without limitation:

- ✓ **Current medication list**
- ✓ **Opioids** you are taking
- ✓ **Most recent office notes** pertaining to the treatment of your pain. This includes surgery or procedure notes, clinic notes from other specialists, and any previous pain management notes.
- ✓ **MRI or X-Ray Films** pertaining to your pain

Updated Plan of Care

This includes ensuring completeness in diagnostic imaging, physical therapy, injections, as well as safely adjusting levels of medications to bring them within our guidelines.

Due to the risk of accidental overdose, no alcohol use is permitted while on Chronic Pain Medications.

Due to the risks and lack of evidence of superiority over the gold standard treatments the use of marijuana (medical and otherwise) will not be permitted.

Due to the risk of accidental overdose and/or death from combining tranquilizers and opioids, we will decrease your use of tranquilizers.

Due to the number of people misusing medications across the state and nationally, we will be working closely with multiple agencies within the state to ensure those who follow proper precautions will have continued access to the medications they need.

Thank you for choosing us to help you with your pain management needs.

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No Show/Cancellation Policy & Procedures

We see patients on an appointment basis and your appointment is reserved exclusively for you. We respect your time and make every effort to remain on schedule; therefore, we must request that you check-in on time for your appointment. Arrival time is based on appointment type and is determined by each department. Expected arrival time is communicated to you when you book your appointment.

We understand that circumstances arise that prevent patients from keeping appointments. If you are unable to keep an **FMC – Interventional Pain appointment**, please call and cancel or reschedule by 3 pm the day before your scheduled appointment. If you fail to do so, there will be a **$25.00 no show/cancellation fee** that will be charged to you.

If you are unable to keep an appointment with a **Specialist**, you must call 48 hours in advance to cancel or reschedule. If you do not there is a **$250 no show/cancellation fee** that will be charged to you.

Patient Name D.O.B.

Patient Signature Date

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Controlled Substance Agreement

Patient Name_____DOB_____Pharmacy_____

Please read and initial the following statements and sign the bottom:

I understand that I have a complex chronic pain problem which may benefit from physical therapy, psychological therapy, behavioral medicine strategies, as well as medications to include the prescription of opioid (narcotic) pain medication. These treatments are designed to help me improve my ability to function. I understand that the long-term risks of medication dependency and medication tolerance outweigh the benefits unless function is improved along with the pain. Therefore, my prescribed medication will not be continued if my level of function fails to improve, even if my pain is reduced. I also recognize that my active participation in the management of my pain is essential. I agree to actively participate in all aspects of my treatment plan to maximize functioning and improve coping with my condition._____*(Initial)*

I understand that these medications have the potential for abuse and use by someone else. I understand that they may be hazardous or deadly to a person who is not tolerant to their effects, especially children. I understand that the Federal Government requires strict accountability for use of these medications, and that I will be subject to a higher level of scrutiny which requires full cooperation in order to comply with all State and Federal regulations. I understand that if any regulatory agency or authority have questions concerning my treatment, I waive all confidentiality, and they may be given full access to my records concerning these medications._____*(Initial)*

I understand that misusing or abusing my medication, forging, altering, or falsifying a prescription will result in immediate dismissal from FMC Interventional Pain, reporting to appropriate regulatory authorities, and commencement of criminal proceedings as required by law._____*(Initial)*

I will not share, sell, trade or otherwise permit others to have access to my medication for any reason. I will keep them in a safe, lock box, or other secured device or area._____*(Initial)*

I understand that it is my responsibility to take care of my medications. Damaged, lost, misplaced, or stolen medications will not be replaced, and if my medications are stolen, I will promptly file a police report and deliver a copy of this report to my physician._____*(Initial)*

I agree to submit urine, saliva, hair, and blood tests to determine compliance with my planned treatment. I agree to bring the opioid (narcotics) medication(s) with me in their original containers to each clinic visit. Pill and patch counts will be done on a random basis to confirm my compliance and appropriate usage levels. I understand that FMC Interventional Pain will also utilize the Alaska electronic prescription monitoring program to confirm compliance._____*(Initial)*

I will not consume other medications, alcohol, or any recreational or illicit substances in conjunction with my prescribed medications as the combination may be unpredictable or lethal._____*(Initial)*

I will not be involved in any activity that may be dangerous to myself or anyone else while taking these medications. I am aware that even if I do not notice it, I may be drowsy or not thinking clearly, and my reflex reaction time might still be slowed. Such activities include, but are not limited to: using heavy equipment or motor vehicles, working at unprotected heights or being responsible for another individual who is unable to care for themselves. I understand that if I am stopped by police while driving, I may be issued a DUI and arrested._____
(Initial)

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Females: I certify that I am not currently pregnant and will take the necessary precautions to prevent pregnancy during the course of my treatment at FMC Interventional Pain._____*(Initial)*

I will obtain prescriptions for opioids (narcotics) and other controlled medications only from FMC Interventional Pain. I am not allowed to receive the same type of medication from another physician (including the Emergency Room or clinic) without the express consent or consultation with FMC Interventional Pain. If I am seen elsewhere for a nonrelated unavoidable emergency requiring controlled substances, I agree to contact FMC Interventional Pain within 24 hours._____*(Initial)*

I will have prescriptions filled at only one pharmacy and tell my physician at FMC Interventional Pain the name, address, and phone number of the pharmacy. I will count my pills from the pharmacy and will ensure the proper amount is received. Any shortage found must immediately be discussed with the pharmacy upon receipt of the filled prescription. I give FMC Interventional Pain permission to discuss all diagnostics and treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability._____*(Initial)*

I will read and comply with all medication inserts._____*(Initial)*

I will take the medication following the dosing schedule prescribed to me. If I am unable to tolerate any medication, I will promptly notify my physician at FMC Interventional Pain and bring the unused portion of my prescription into the center so that it may be accounted for. I will be instructed on proper disposal of the medication, prior to receiving a substitute. _____*(Initial)*

I will meet regularly with my physician at FMC Interventional Pain to assess my progress. The frequency of visits is dependent on my response to the treatment program. I agree to keep all scheduled appointments. I understand no medications will be given for cancelled or no-show appointments. I agree to be prompt to my appointments and understand that if I am late, I may have to reschedule._____*(Initial)*

I agree to contact FMC Interventional Pain at 907-262-7566 AT LEAST 48 hours in advance to my scheduled appointment to reschedule if I am unable to make it and understand that I will not receive my medications until I am seen. Excessive missed appointments may result in dismissal from FMC Interventional Pain._____*(Initial)*

I understand that prescription refills will not be given early for <u>any</u> reason, and that all medication refills involving opioid medication will require an in-person scheduled office visit at the FMC Interventional Pain Clinic. Non-narcotic refills will not be made outside the hours of 8:00 AM to 3:00 PM on Monday through Thursday and 8:00 AM to 1:00 PM on Friday. There will be no refills nights, weekends, or holidays when chart reviews are not possible. Please call seven days prior to your refill date to insure adequate time to process your request without running out of your medication._____*(Initial)*

I will treat everyone at FMC Interventional Pain in a respectful and professional manner at all times. I will not be disruptive or threaten anyone. Calling more than three times in one business day or showing up unannounced seeking medication refills will be considered disruptive. Disruptive behavior will result in dismissal from FMC Interventional Pain._____*(Initial)*

If requested by my physician, I agree to have another individual keep control of the medication and dispense it to me in cases where I do not have the full capacity to comply with this agreement myself._____*(Initial)*

If I deviate from this agreement or the medication loses its effectiveness in increasing my function, I understand that my medication will be promptly tapered or discontinued._____*(Initial)*

Lack of compliance with other prescribed treatments (i.e. other medication, physical therapy, psychological therapy, weight loss, smoking cessation, etc.) will lead to tapering and discontinuation of medications._____*(Initial)*

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If I develop a psychological dependency or addiction to the medication or in the opinion of my physician, I display any drug seeking behavior or other evidence of potential addiction, the medication will be tapered and then discontinued. I understand I may need to undergo inpatient withdrawal (detoxification) or other addiction treatment at my own expense._____*(Initial)*

Failure to follow the terms of this agreement will result in dismissal from FMC Interventional Pain and may exclude me from care at the Family Medical Clinic, but I understand that I may always present for care at an Emergency Department._____*(Initial)*

I have read and understood all my responsibilities, benefits, and risks under this agreement. I have had the opportunity to ask questions about the treatment, alternatives, risks, complications, and/or adverse effects, and benefits of this medication regimen, which have been addressed to my satisfaction. Therefore, I accept the risks and conditions of this chronic opioid (narcotic) analgesic treatment program. I have also received a copy of this document for my own files.

Patient Name	D.O.B.
Patient Signature	Date
Provider's Signature	Date

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Treatment Informed Consent

Chronic Opioid (Narcotic) Therapy for Pain Treatment Information

Your physician may recommend that a maintenance opioid analgesic be given as a trial in order to manage your pain and increase your activities at home and at work. As you begin this treatment program, you should be aware of the following risks associated with the use of this medication.

1. Side effects of these medications: may include drowsiness, dizziness, constipation, nausea, confusion, altered levels of male and female hormones including levels of testosterone and/or respiratory depression including respiratory arrest and death.

    - It usually takes 5 to 7 days for a person to get an idea of how he/she is affected. Frequently these effects diminish in a few days. Any time your dose is changed, you may experience new side effects.
    - Cognitive impairment, mental clouding, and sedation may occur during treatment and may not decrease over time. If the medication is used with other sedatives or alcohol, the resulting heightened impairment is potentially dangerous, even fatal. You must abstain while taking these medications.
    - Constipation is a common side effect. If this is a problem for you, try a stool softener (Docusate, Colace) or mild laxative (MiraLAX) with increased fiber and fruit in your diet. Some people experience nausea with this medication. If you take the medication after eating, nausea may be decreased. Other side effects which infrequently occur are disorientation and sleep disturbances.
    - Dry mouth can be severe enough to result in tooth decay. Drink plenty of water and discuss other preventative options with your dentist.
    - Hyperalgesia is a worsening of pain. This can occur with the use of opioids and is called "Opioid-Induced Hyperalgesia".
    - The use of other medications can increase side effects. It is important that your physician know of all medications you are taking. Medications that make you sleepy (for example, antihistamines in cold preparations and alcohol) will make you sleepier while taking this medication. It is advised that you talk with your physician or pharmacist before buying any over-the-counter products.

2. Risk of psychological dependence on these medications: Psychological dependence is possible. This means there is a continued desire for the mood altering and other psychological effects of the medication and concern for its continued availability. Communication with your physician is necessary for you to understand the role of the medications in your pain management program and to avoid development of this type of dependence.

3. Risk of physical dependence: Physical dependence on these types of medications is very high. It refers to the fact that at higher doses of this type of medication, your body will get used to it. If you stop taking the medication abruptly, your body may react adversely with withdrawal symptoms, which may include: excessive tearing, runny nose, dilated pupils, "goose bumps", abdominal pain, cramping, diarrhea, irritability, a flu-like feeling, sweating, yawning, diarrhea, muscle aches, headache, and insomnia. To prevent these uncomfortable symptoms, you should take your medication regularly and communicate to your physician and side effects. When discontinuing use of medication, taper it down slowly over a period of a few days to a few weeks under supervision of your physician.

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4. Questions and issues of addiction: These questions are frequently on the minds of patients. Psychological and physical dependence are not the same thing as addiction, and they are treated differently. To help prevent the development of psychological dependence or addiction, we have developed a close follow-up system. Addiction is a term to describe deviant behavior where the primary goal is to obtain narcotic analgesics for use other than pain control, such as recreational use and other forms of illicit use. Patients who are using these types of medications for medical reasons and have a clear understanding why they are using them are at a very low risk for this problem, about the same as the general population. If any of these dependence characteristics develop, we will inform you about it and appropriate measures will be taken.

5. Tolerance to the medications: This may occur in the course of your treatment. Tolerance refers to the decreasing effect of a medication at a stable dose. This is different than increasing the dose to manage an increase in pain. This would mean that your body is adapting to the medication and that the medication is losing its strength. This may call for tapering and stopping of the medications to regain sensitivity to the medication.

6. Risk to unborn children: If you are a female of childbearing age and become pregnant, there is the risk that any child born will likely be physically dependent at birth. We strongly recommend that you maintain safe and effective birth control/abstinence while in this program. If your become pregnant, you should immediately contact your physician so that the medication can be tapered and stopped. If you are of child-bearing age and you are planning a family, you should contact your physician immediately to discontinue therapy as birth defects can occur.

7. Risk of not receiving this treatment: You should understand that your physician believes that the potential benefit of this treatment outweighs these potential risks and therefore is recommending it to you. However, it is your choice whether or not you accept this treatment plan. If you choose to not follow this treatment, your physician will continue to offer other alternative treatments for your pain. You are free to choose to refuse opioid medications.

8. Safe keeping and disposal of opioids: The theft and abuse of prescription medicines is a serious problem. We recommend these medications be kept in a locked storage area. Additionally, young children are at risk of exposure when being held by someone wearing a partially detached patch which can then transfer to the child. Exposure of young children to an opioid patch can lead to serious adverse events, even death, due to the amount of medication present in the patches. This can even occur with used patches which still contain a considerable amount of medication. Young children are at a particular risk of accidental exposure to opioid patches. Their mobility and curiosity provide opportunities for them to find lost patches, take improperly discarded patches from the trash, or find improperly stored patches, all of which may result in patches being placed in their mouths or sticking to their skin. Much of this risk applies to pets as well. The FDA recommends that the adhesive side of the patch should be folded together and then the patch should be brought in to FMC Interventional Pain or the Family Medical Clinic.

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Evaluation of Treatment

Evaluation by clinic visits will assess: (1) how effective the treatment is in reducing pain; (2) whether or not it improves your function (increase your activities t home or work); (3) any adverse effects you have experienced (excessive sedation, constipation, worsening depression); (4) accidental or purposeful medication misuse/abuse; or (5) an increased dose from what is recommended by your physician. Each evaluation will be documented in your medical record. If there is no demonstratable improvement of function or quality of life or if you experience bothersome side effects, the medication will be tapered and finally discontinued.

I understand the nature and purpose of this treatment, and I affirm that the risks, benefits, possibility of complications, as well as the expected results, and medical alternatives, including the expected consequences of refusing the treatment, have been explained to me by my physician and that I have been given an opportunity to ask and have my questions answered. I have received a copy of this informed consent for my own files.

Printed Name DOB

Patient Signature Date

Pain Questionnaire

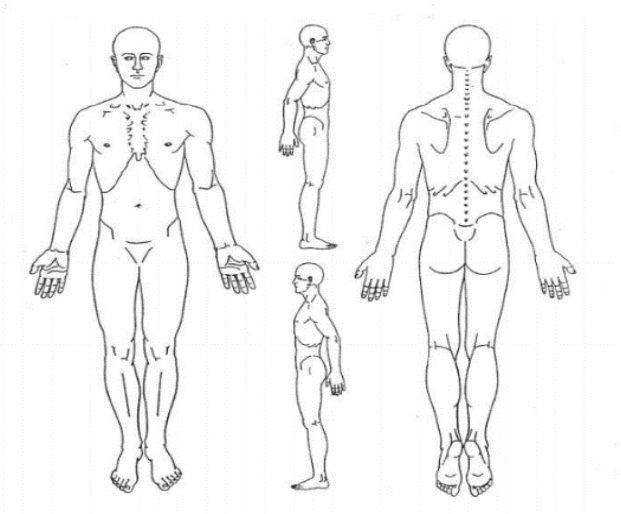
Chief Complaint:
Where is your worst pain?

History of Present Illness:

What is your realistic goal of treatment?

Location of Your Pain:	☐ Neck	☐ Right Arm	☐ Left Arm	☐ Low Back	☐ Right Leg	☐ Left Leg	☐ Whole Body	☐Other
Duration of Your Pain:	Since:							
Onset:	☐ Lifting	☐ Falling	☐ Car Accident	☐ Twisting	☐Unknown	☐ Other		
Onset:	☐ Sudden	☐ Gradual						
Timing:	☐Constant	☐Intermittent	☐Constant Baseline with Intermittent Pain	☐ Worse in AM	☐ Worse in PM	☐ Other		
Quality:	☐ Burning	☐ Electrical	☐ Shooting	☐ Sharp	☐ Aching	☐ Cramping	☐ Other	☐ All
Exacerbated By:	☐ Sitting	☐ Standing	☐ Walking	☐ Bending	☐ Lifting	☐Movement	☐ Weather	☐ All
Relieved By:	☐ Sitting	☐ Standing	☐ Laying	☐ Rest	☐ Heat	☐Medication	☐Injections	☐ Ice
Severity:	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10							
Quality of Life:	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10							

Please mark your areas of pain on the figure.

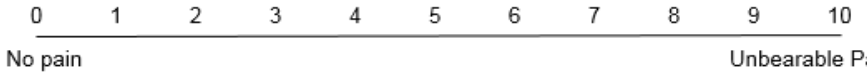


Name:_____

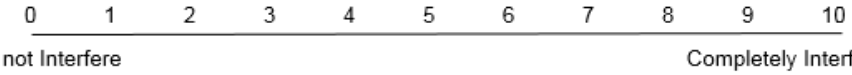
Date:_____DOB:_____

Injections	Previous Treatments	Medications	Surgeries
☐ Epidural Steroid Injection	☐ Physical Therapy	☐ NSAIDs (Motrin, Ibuprofen, Aleve, Naproxen, Mobic, Celebrex, etc.)	☐ Neck Surgery
☐ Radiofrequency Ablation	☐ Chiropractic/Osteopathic Manipulation	☐ Anticonvulsants (Gabapentin, Neurontin, Lyrica, Topamax, Keppra, etc.)	☐ Low Back Surgery
☐ Nerve Blocks	☐ TENS Unit	☐ Antidepressants (Prozac, Zoloft, Celexa, Lexapro, Cymbalta, Effexor, Wellbutrin, etc.)	☐ SCS
☐ Joint Injections	☐ Psych/Cognitive Behavioral Therapy/Biofeedback	☐ Muscle Relaxers (Flexeril, Robaxin, Skelaxin, Soma, Baclofen, Tizanidine, etc.)	☐ Pump
☐ Trigger Point	☐ Braces	☐ Anxiolytics (Xanax, Klonopin, Valium, etc.)	☐ Knee Replacement
☐ Prolotherapy/PRP	☐ Acupuncture/Massage	☐ Topicals (Lidocaine, Lidoderm, Pennsaid, Voltaren Gel, Capsaicin, Compounded Cream, etc.)	☐ Hip Replacement
☐ Intramuscular Steroid Injection	☐ Traction	☐ Opioids (Morphine, Codeine, Hydrocodone, OxyContin, Fentanyl, Duragesic, Tramadol, Nucynta, etc.)	☐ Abdominal Surgeries

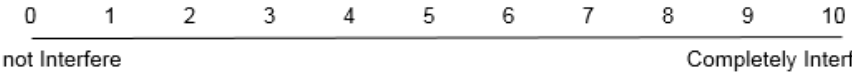
1. What number best describes your pain on average in the past week?



2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?



3. What number best describes how, during the past week, pain has interfered with your general activity?



Past Medical History

Medical Problem	Details

Surgery	Date	Details

Social History:

1. Marital Status: ☐ Single ☐ Married ☐ Significant Other ☐ Separated ☐ Divorced ☐ Widowed
2. Children: Ages _____
3. Who lives with you at home? _____
4. Use of Alcohol: ☐ Never ☐ Rarely ☐ Weekly ☐ Daily
5. Use of Tobacco (smoke or chew): ☐ Never ☐ Previously ☐ Active at___packs/___cans per day
6. Use of Recreational Drugs (Marijuana, Methamphetamine, Ecstasy, Cocaine)

   ☐ None ☐ Some (Type/Frequency_____)

7. Have you or a family member ever had a problem with dependency or abuse of prescription or non-prescription drugs (including alcohol)?

   If yes, indicate so on the chart.

Type	Family	Personal
Alcohol		
Illegal Drugs		
Prescription Drugs		

8. Have you ever been physically abused? ☐ Yes ☐ No
9. Were you ever sexually abused as a child? ☐ Yes ☐ No
10. Psychological History: Have you ever been diagnosed with any of the following?

Depression	Y|N	Obsessive Compulsive Disorder	Y|N	Bipolar Disorder	Y|N
Suicide Attempt	Y|N	Attention Deficit/Hyperactivity	Y|N	Schizophrenia	Y|N

11. Occupation_____Hours per Day_____What sort of physical activity is involved? _____
    a. Retired: ☐ Yes ☐ No Since when?
    b. Disabled: ☐ Yes ☐ No Since when?
12. Is this a work related injury? ☐ Yes ☐ No
13. Is Worker's Compensation involved? ☐ Yes ☐ No

    If so, date of injury? MM/DD/YYY _____
14. Are you pregnant? ☐ Yes ☐ No

Medications:

Drug Allergies:

Review of Symptoms:

Constitutional:	☐ Night Sweats	☐ Fevers	☐ Chills	☐ Weight Loss	☐ Weight Gain
Head:	☐ Head Trauma		☐ Headache		
Eyes:	☐ Change in Vision		☐ Eye Pain	☐ Excess Tearing	
ENT:	☐ Changes in Hearing		☐ Changes in Smell	☐ Changes in Swallowing	
Neck	☐ Pain	☐ Decreased Range of Motion			
Respiratory:	☐ Cough	☐ Wheezing		☐ Shortness of Breath	☐ Coughing Up Blood
Cardio:	☐ Chest Pain		☐ Palpitations	☐ Shortness of breath on exertion	
GI:	☐ Nausea	☐ Vomiting	☐ Constipation	☐ Diarrhea	☐ Black or Bloody Stool
GU:	☐ Incontinence		☐ Difficulty Urinating	☐ Having to Urinate Frequently	
Muscles, Bones, Ligaments:	☐ Pain	☐ Arthritis	☐ Joint Swelling	☐ Decreased Range of Motion	
Neuro:	☐ Seizures	☐ Syncope		☐ Memory Problems	☐ Dizziness
Skin:	☐ Itching	☐ Ulcers	☐ Rashes	☐ Changes in Hair or Nails	
Psych:	☐ Changes in Mood		☐ Hallucinations	☐ Thoughts of Self Harm	
Endo:	☐ Abnormal Menstrual Cycles		☐ Sexual Difficulty	☐ Heat and Cold Intolerance	
Heme:	☐ Easy Bruising or Bleeding				
Allergy:	☐ Foods	☐ Animals	☐ Insect	☐ Materials	

Have you ever been discharged from a clinic? ☐ Yes ☐ No

If yes, please explain what happened and the name of the clinc: _____

Have you done physical therapy to treat this problem? ☐ Yes ☐ No

Did it help wiith your pain? ☐ Yes ☐ No

When did you go? _____

For how long? _____

Aggravating Factors:

☐ Sneezing ☐ Sitting ☐ Twisting
☐ Coughing ☐ Standing ☐ Bowel Movements
☐ Lifting ☐ Walking ☐ Other: _____
☐ Bending ☐ Lying Down

Relieving Factors:

☐ Heat ☐ Rest ☐ Pain Medication
☐ Ice ☐ Laying Down ☐ Bending Forward
☐ Physical Therapy ☐ Standing Up ☐ Other: _____

Geralized Anxiety Disorder 7-item (GAD-7) Scale				
Over the last two weeks, how often have you been bothered by the following problems?	Not sure	Several Days	Over Half the Days	Nearly Every Day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble Relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column				
Total Score (add your column scores) =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not Difficult at All
- ☐ Somewhat Difficult
- ☐ Very Difficult
- ☐ Extremely Difficult

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessinggeneralized anxiety disorder. Arch Intern Med. 2006;166:1092-1097

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
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
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005