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ROSTAM KHOSHSAR, MD

Pain Management

To: Dr. Khoshsar's Patients

As a reminder, at the time of your scheduled initial visit, please be informed of the following:

- Kindly arrive a half hour early prior to your scheduled appointment time
- Bring all test results and films with you at the time of your visit
- Bring all original medication bottles
- Bring all forms with you that were sent to you in the mail to avoid delay in filling up paperwork at the time of your visit
- Expect a waiting time of an hour until the Doctor sees you.

Thank you very much for your patience and kind consideration regarding this matter.

Biohealth Pain Management
Patient Registration Form

PATIENT NAME: ________________________________ AKA: _______________

SSN:_____________DOB:_______ Age _______Sex_________Marital Status: ___________

Address: ____________________________City/ State: ______________Zip: _____________

Primary Contact Number: _______________ Alternative Number: __________________

Primary Care Physician: _______________ Referring Physician: __________________

Ethnicity: ___________________________ Primary Language: ____________________

IN CASE OF EMERGENCY

Relative/friend: ____________________________ Relationship: _______________________

Primary Phone Number: ______________________ Alternative Number: _________________

RESPONSIBLE PARTY IF OTHER THAN PATIENT

Name: ____________SSN: _____________ Relationship: _______ DOB: ___________

Address: ____

Contact Number: _____________________ Alternative Number: _______________________

INSURANCE INFORMATION

Primary Insurance: ______________ Secondary Insurance:_____________

Member I.D. __________________ Member I.D. __________________

Group Number: _______________________ Group Number: _______________________

Authorization to Allow Disclosure of Protected Health Information

Date: ________________________

Name: ____

Date of Birth: ____________________________________

I _____________________________ authorize the following individual (s) to receive any and all information regarding my medical care. I understand that this authorization will be in effect until revoked by me in writing.

	Name	DOB	Relationship
1.	________________________	____________	__________________
2.	________________________	____________	__________________
3.	________________________	____________	__________________

Signature of patient ____

If patient unable to properly sign, patient will sign by marking an “X”. A witness is required when signed by marking an “X”. Witness must not be an individual named above.

Name of witness: ____

Signature of witness: ____

MEDICATION MANAGEMENT AGREEMENT

This agreement between ______________________________, (patient) and the Physician is for the purpose of establishing an understanding between the doctor and patient on clear conditions for their pain management program, which may include the prescription and use of pain controlling medications prescribed by the doctor for the patient. The Doctor and patient understands that this agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship.

As consultants in Pain Management, we will recommend and/or initiate therapy for your chronic pain condition. This may include performing procedures and formulation an optimal medication regimen. A reduction in the intensity of your pain and an improvement in your quality of life are the goals of this program. An agreement between ____________ (patient) and your primary care physician may be necessary prior to initiating opioids medications.

I agree to and accept the following conditions for my pain management program, which may include pain medications prescribed by my Pain Management Doctor:

1. Opioids may cause drowsiness. I understand that they are strong medications for pain relief and I have been informed of the risk and side effect involved with taking them. Overdose of this medication may cause death by stopping of my breathing. This can be reversed by emergency personnel if they know II have taken opioid painkillers. It is suggested that I wear a medical alert bracelet or necklace that contains this information. ____________
2. I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving or the operation of machinery. If there are any suggestions of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated, or I have stopped the medication long enough for the side effect s to resolve. ____________
3. I realize that all medication have potential side effects. I understand, accept, and agree that there may be unknown risks associated with the long term use of controlled substances and that my physician will advise me as knowledge and training advances and will make appropriate treatment changes. ____________
4. I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids medication, my child would be physically dependent on the opioids, and withdrawal can be life threatening for a baby. If a female of childbearing age, I certify that I am not pregnant and I will use appropriate contraceptive measures during the course of treatment with opioids. ___________
5. I understand that I must contract my pain physician before taking Benzodiazepines (drugs like Valium or Ativan), sedatives, or muscle relaxants (drugs like soma, Xanax, and florinal) and antihistamines (drugs like Benadryl). I understand that the combination use

of the above drugs and opioids, as well as alcohol and opioids, may produce profound sedation, respiratory depression, blood pressure drop and even death. I will not use recreational drugs while on opioids. If consumed, the consequence will be termination from the program. ____________

6. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-28 hours of the last does. I agree that continued refill of opioid medications may be contingent upon compliance with the program in general as well as other chronic pain treatment modalities recommended by my doctor. _________

7. I will keep all scheduled appointments in the pain clinic. I will bring in medication bottles to each visit. Noncompliance such as frequent cancellation of appointment may result in termination of my treatment. ______

8. I understand that the main treatment goal is to improve my ability to function and/ or work and/ or reduce pain. In consideration of that goal and the fact that I may receive patent medication to help me reach that goal I agree to help myself by the following better health habits: exercise, weight control, and avoiding the use of tobacco. I must also comply with the treatment plan as prescribed by my doctor. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment. ____________

9. I agree to comply fully with all aspects of my treatment program, which may include behavioral medicine and physical therapy. Failure to do so may lead to discontinuation of your medication and referral to an outside physician. ___________

10. Refills of controlled substance medication:

    - Will be made only during the office hours 9am to 3pm, Monday thru Friday, refills will not be made at night, on holidays, or weekends.
    - Will not be made if I "run out early" or "loose a prescription" or "spill" or misplace my medication." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
    - Will not be made as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow". I will call at least 48 hours ahead if I need assistance with a controlled substance medication prescription.
    - If your medications are stolen and you complete a police report regarding the theft, and exceptions may be made.

11. I agree that I will use my medication at a rate no greater than the prescribed rate unless it is discussed directly with my pain physician
12. I will not use any illegal controlled substances (cocaine, heroin, etc)
13. I will not share, sell, or trade my medication for money, goods, or services.
14. I will discontinue all previously used pain medications, unless told to continue them.
15. I will not attempt to get pain medication from any other health care provider without telling them that I am taking pain medications, unless told to continue them. ____________
16. I understand that once my pain management is optimized, refill of my medications will be transferred to my primary care physician. If I do not have a primary care physician at the time, I will have 1-3 months to find a doctor that will take over my care and prescribe me medications. __________
1. I understand that this medication regimen will be continued for a definitive time period as determined by my Doctor, My case will be reviewed at the end of that period. If there is no evidence that I am improving or that progress is being made to improve my function or quality of life, the regimen will be tapered to my pre-trial medications and my care will be referred back to my primary care physician. ____________
2. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my pain medication and I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the California Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize the doctor to provide a copy of this Agreement to my pharmacy, or healthcare providers, and any emergency department upon request. ____________
3. I understand that random urine testing may be employed to monitor effectiveness and compliance of my medication regimen. __________

My Pain Management physicians and I agree that this contract is essential to my doctor's ability to treat my pain effectively and that my failure to comply with the agreement may result in the withdrawal of all prescribed medication by my doctor and termination of the doctor/ patient relationship.

I have read the above agreement and understand the rules regarding prescribing and use of opioid medication. I agree to comply with this program. I also agree to testing and detoxification if necessary,

We understand that emergencies can occur and under some circumstances, exceptions to these guidelines may be made, Emergencies will be considered on an individual basis.

If, at any time, you are concerned about your medication or side effects of our medication, you may call the office at 424-488-6369 and leave a message. A physician or nurse will return your call.

I agree to use ____________________________, pharmacy, located at: _____________________

____________________Telephone number: _______________________, for all my pain medication. If I change pharmacy for any reason, I agree to notify the doctor at the time I receive a prescription and advise my new pharmacy's address and telephone number.

This agreement is entered into on this day of _______________________, 20__________.

Patient Signature ___________________ Physician Signature________________________

Witness Signature________________________

ALLERGY/ HISTORY MEDICATIONS FORM

Name: ______________________________ Date: ___________________

DOB: ____________ MRN# _________________

Allergies:
Please list any food, environment or medication allergies:

____

____

History:
Have you ever had: (circle one)

1.	Epidural Steroid Injection:	Yes	No
2.	A surgical operation requiring an anesthetic	Yes	No
3.	Any anesthetic complication or problem?	Yes	No
4.	A cold within the las two weeks?	Yes	No
5.	Rheumatic fever?	Yes	No
6.	Frequent headaches?	Yes	No
7.	Back Pain?	Yes	No
8.	Scoliosis	Yes	No
9.	Seizure disorder, epilepsy?	Yes	No
10.	Muscle weakness in arms or legs?	Yes	No
11.	Are you pregnant?	Yes	No
12.	Do you smoke?	Yes	No
13.	Do you faint easily?	Yes	No

Medication:
Are you presently taking:

1.	Aspirin or any medication containing aspirin?	Yes	No
2.	Cortisone or other steroids, now or in the past year?	Yes	No
3.	Insulin or oral medication for diabetes?	Yes	No
4.	High Blood pressure medication?	Yes	No

Patient Signature _________________________________ Date: __________________

Physician Signature ________________________________Date: __________________

Patient Information

Name: ________________________________DOB: ___________________MRN# ___________

Occupation: ______________________

Pain History:
Where is your pain located? If in more than one place, please list in order of severity, the worst pain first.

____

____

____

How long have you had this problem?

____

How did the pain start (accident, etc.)?

____

____

Visual Analog Pain Scale
On a scale from 0-10, please rate the intensity of your pain. Ten represents the pain at its worst; zero represents the absence of pain. Please draw a line on the scale that best represents your level of pain.

____
0 1 2 3 4 5 6 7 8 9 10

When pain is at its worst: __________out of 10

When you have the least pain: ____________out of 10

At the present time: _______________out of 10

What words would you use to describe your pain (circle)?

Dull Aching Throbbing Burning Radiating

Sharp/Stabbing Pulsating Other:_______________________________________

When does your pain occur?

Always there Intermittent-# times per day ________# times per week: ______________

Intensity of pain: Steady Increases and decreases

My pain is better: Upon rising Mid Day End of day Late at night

How well do you sleep? Well Poor Only with Pills

What seems to make your pain worse?

Movement Daily activity Sitting Walking Standing

Bending Lying down Sustained position Sexual Activity

Other: ____

What pain medications are you currently taking? What effects do they have?

Medication	How Helpful	What side effects?

What other pain treatments have you received?

Physical Therapy Chiropractic Chronic Pain Management Programs

Epidurals/Blocks Biofeedback Acupuncture Trigger Point inj

TENS Unit Surgery Other: _____________________________

List all surgeries: ____

____

____