ADVANCED PAIN MANAGEMENT
Pain Management Agreement

Patients Name: ____

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician comply with all state and federal regulations concerning prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

1. You should use one physician to prescribe and monitor all opioid medications and adjunctive analgesics.
2. You should use one pharmacy to obtain all opioid prescriptions and adjunctive analgesics prescribed by your physician.

   Pharmacy: ____ **Phone Number:** ________________________

3. You should inform your physician of all medications you are taking, including herbal remedies, since opioid medications can interact with over-the-counter medications and other prescribed medication, especially cough syrup that contains alcohol, codeine, or hydrocodone.
4. You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment.
5. Prescriptions for pain medicine or any other prescriptions will be done only during an office visit or during regular office hours. No refills of any medications will be done during the evening or on weekends.
6. You must bring back all opioid medications and adjunctive medications prescribed by your physician in the original bottles.
7. You are responsible for keeping your pain medication in a safe and secure place, such as a locked cabinet or safe. You are expected to protect your medications from loss or theft. Stolen medications should be reported to the police and to your physician. Your physician may choose not to replace the medications or to taper and discontinue the medications.
8. You may not give or sell your medications to any other person under any circumstances. It's against the law and you may endanger a person's health.
9. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.
10. At the initial and follow-up appointments, you will communicate fully and to the best of your ability to your physician, your pain level and functional activity along with any sided effects of the medication.
11. You should not use any illicit substances, such as cocaine, marijuana, etc. while taking these medications. This may result in a change in your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship.
12. The use of alcohol and opioid medications is contraindicated.
13. You agree and understand that your physician reserves the right to perform random or unannounced urine drug testing. If requested to provide a urine sample, you agree to cooperate. If you decide not to

provide a urine sample, you understand that your doctor may change your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship. The presence of a non-prescribed drug(s) or illicit drug(s) in the urine can be grounds for termination of the doctor/patient relationship. Urine drug testing is not forensic testing but is done for your benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain. I further agree that I will submit to random pill counts within 24 hours of the request.

14. There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing).
15. Physical dependence and/or tolerance can occur with the use of opioid medications.

    Physical Dependence means that if the opioid medication is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal physiological response. The withdrawal syndrome could include, but not exclusively, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in one's mood.

    It should be noted that the physical dependence does not equal addiction.

    Addiction is a primary, chronic neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life.

    Tolerance means a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain.

16. If you have a history of alcohol or drug misuse/addiction, you must notify the physician of such history since the treatment with opioids for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery is a must.
17. You agree to allow your physician to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions if the physician feels necessary.
18. You agree to a family conference or a conference with a close friend or significant other if the physician feels necessary.

The above agreement has been explained to me by Toledo Clinic Advanced Pain Management staff. I agree to its terms, in order for Toledo Clinic Advanced Pain Management staff to provide quality pain management using opioid therapy to decrease and increase my function.

Patient's signature ____ **Date:** ____________________

Witness's signature ____ **Date:** ____________________

Date: ________________

Patient Information

Last Name: ______________________________ First Name: ___________________________ M.I. _______

____
Street Address City State Zip Code

Home Phone: _______________________________ Work Phone: ______________________ SSN#_______________

Date of Birth: ________________ Age: ________________ Marital Status: _______________

Occupation: ___________________________________ Employer: ______________________________________

____
Employer Address City State Zip Code

Next of Kin: ___________________ Relationship: ___________________ Phone: _________________________

Address: ____

List of Any Known Drug Allergies: ____

Referring Physician: ____ Phone: _________________________

Mailing Address: ____

Primary Care Physician: ____ Phone: _________________________

Mailing Address: ____

Primary Insurance: ____ ID#: ____________________________

Group or Policy#: _________________________ Subscriber: ______________________ Birth Date: ______________

Subscriber's Employer: ____ Employer's Phone: ___________________

____
Subscriber's Employers Address City State Zip Code

Secondary Insurance: ____ ID#: ____________________________

Group or Policy#: _________________________ Subscriber: ______________________ Birth Date: ______________

Subscriber's Employer: ____ Employer's Phone: ___________________

____
Subscriber's Employers Address City State Zip Code

I authorize the release of any medical information necessary to my insurance company to enable them to process any claim.

Signed: ____ **Date:** ___________________________

ADVANCED PAIN MANAGEMENT
Release of Verbal Medical Information

Patient Name: ____ Date of Birth: _______________________

I, ____ hereby authorize Toledo Clinic Advanced Pain Management to release verbal information concerning my treatment to the following person(s).

____ ______________________________
Name Relationship

____ ______________________________
Name Relationship

____ ______________________________
Name Relationship

Purpose or need for such release of information: **the conveyance of medical information.** I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. Otherwise, this consent will expire automatically on the date below or upon the occurrence of the event or condition specified below.

By signing this form, I consent to the disclosure of information about me as described and, in the event such disclosure is to be made to an attorney, I consent to such redisclosures of that information as may be incidental to use of that information in litigation in which I am a complaining witness or to which I am a party. I hereby waive and release Toledo Clinic Advanced Pain Management and its physicians from any liability arising out of the release of medical records in accordance with this authorization.

Executed this _____________ day of _____________.

____ ______________________________
Patient Signature Date

____ ______________________________
Guardian Signature Date

ADVANCED PAIN MANAGEMENT

Medical and Pain History

Patient Name: ____ Date of Birth: _______________________

Medical and Pain History

Chief Pain Complaint

What's the location of the pain you want treatment for the most?

Back, buttock, hip joint, knee, shoulder, chest, abdomen, muscles, neck, head, face

Does it travel to anywhere else?

What is the character of this pain?

Burning, aching, sharp, shooting, stabbing, raw

What do you think is causing it?

When did it start to become serious?

Do you have numbness, tingling, or weakness due to this problem? Where?

Does this problem cause you pain all the time, almost all the time, much of the time, or just sometimes?

THIS SIDE IS FOR PHYSICIAN USE ONLY

Medical and Pain History

Patient Name: ______________________________

Is there a time of day when the pain is at its worst?

From 0 to 10, how severe is it most of the time?
0 no pain, 10 unbearable

What makes it feel worse?
Position, certain movements, heat, cold

What makes it feel better?
Heat, cold, movement, rest, medicine

What test have been done?
MRI, CT, EMG, X-ray, Labs

What has worked best?

What other doctors have you seen for this?

What have they recommended?

THIS SIDE IS FOR PHYSICIAN USE ONLY

Medication and Allergy History

Patient Name: ________________________________

	Drug Name	Tablet Strength (mg)	How many tablets at a time?	How many times per day?	Who is prescribing this med for you?
Pain Relievers					
Anti-Inflammatory and Arthritis					
Nerve Medications					
Muscle Relaxants					
Any other Medication your taking					

Are you allergic to any medications, latex, iodine, or x-ray dyes?

Surgical and Anesthetic History

Patient Name: ________________________________

Surgical History

Please circle any of the following operations you have had.

Heart Bypass, Angioplasty, Stent, or Valve

Head

Neck

Shoulder

Back

Lung

Breast

Stomach

Gall Bladder

Hysterectomy

Kidney

Hip, Knee

Have you had any other operations?

Anesthetic History

Have you had any problems or needed special precautions related to anesthesia?

Have any relatives or family members developed a high fever (malignant hyperthermia) or died during anesthesia?

THIS SIDE IS FOR PHYSICIAN USE ONLY

Medical, Family and Psychological Health History

Patient Name: ______________________________

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Medical History

Please circle any medical conditions that you have (or have had).

Stroke, Seizure, Headache, or Depression

Alcohol or Substance Abuse

Cancer

Thyroid Disease

High Blood Pressure

Heart Attack, Angina, Arrhythmia or
Congestive Heart Failure

Asthma, Bronchitis, Emphysema

Ulcers or Reflux

Hepatitis

Pancreatitis

Diabetes

Arthritis, Lupus, or Osteoporosis

Blood Clots, Anemia, or Sickle Cell Disease

Neuropathy or Neuralgia

Do you have any other medical conditions?

Family History

Do (or did) your parents have any medical illnesses?
Heart, Lung, Arthritis, Diabetes, Cancer, Neurologic

Has anyone in your family had the same problem as the one that is causing you pain?

Psychological Health History

Have you ever received psychological evaluation, outpatient counseling, or inpatient treatment?

Social History

Patient Name: ______________________________

Please list all the members of your household, their ages, and their relationship to you.

Are you employed?

Full-time, Part-time, Looking-for-work, Retired, Unemployed

Do you receive (or are you applying for) disability income?

Partial Total Temporary Permanent

Are you involved in (or considering) any legal proceedings related to your pain problem?

Disability Personal Injury
Works Compensation Medical Malpractice

Do you now (or have you ever been) a user of tobacco, alcohol, prescription drugs, or non-prescription drugs?

Have you ever had (or has any doctor, family member, or co-worker ever wanted you to have) evaluation or treatment for use of alcohol, prescription drugs, or non-prescription drugs?

THIS SIDE IS FOR PHYSICIAN USE ONLY

Systems Review

Patient Name: ________________________________

Please circle any symptoms or complaints you have of the items in this list.

THIS SIDE FOR PHYSICIAN USE ONLY

General
Disturbed Sleep
Weight Gain or Loss
Fever or Sweats
Chronic Fatigue

Musculoskeletal
Bone Pain
Joint Pain
Muscle Pain

Eyes
Cataracts
Blurred or Double Vision

Skin
Rash
Redness
Eczema or Psoriasis

Head & Neck
Headache
Hearing Loss
Balance Problems
Swollen Glands

Neurologic
Seizures
Weakness
Paralysis

Cardiovascular
Palpitations
Chest Pain
Swelling (Edema)

Psychologic
Depression
Mood Swings
Anxiety
Suicidal Thoughts
Panic Attacks

Respiratory
Shortness of Breath
Cough
Wheezing

Endocrine
Bruising
Clots
Hemophilia
Anemia

Gastrointestinal
Nausea
Vomiting
Loose Stool
Constipation
Rectal Bleeding

Blood & Immune
Bruising
Clots
Hemophilia
Anemia

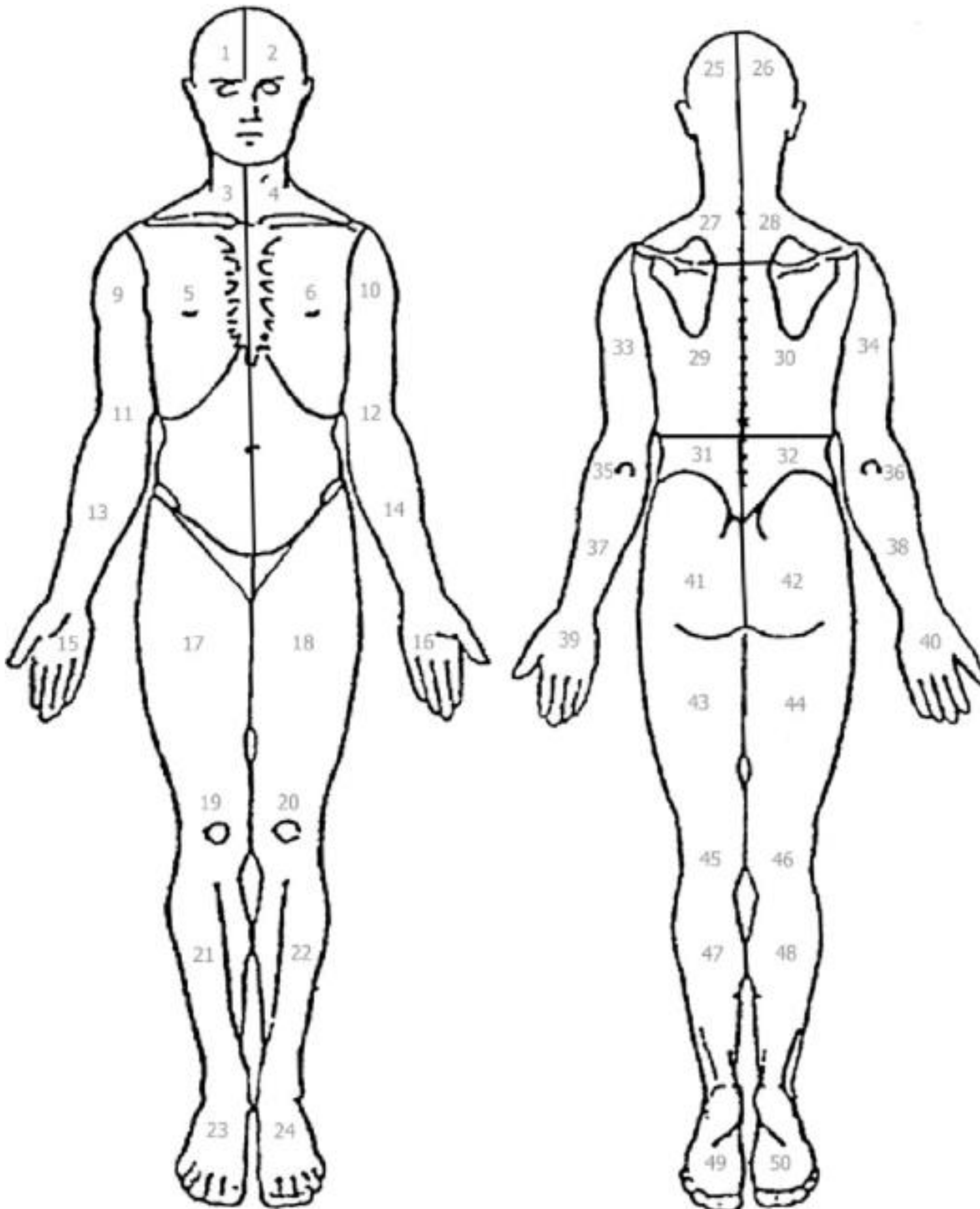
Kidney & Bladder
Frequency
Urgency
Hesitancy
Bloody or Rusty Urine

Allergy & Immunology
Seasonal Allergies
Environmental Allergies
Immune Deficiency

Patient Name: ______________________________

Pain Diagram

On these diagrams, please draw the location of the pain you want treatment for the most.
Please use pen for the severe area(s) and pencil for any areas the pain travels to.



Patient Signature: ______________________________ Date: ____________________

Physician Signature: ______________________________ Date: ____________________

Dear Patient,

Patient Name: ____

Health Insurance: ____ Patient's ID#: ____________________

Member's Name: ____ Member's ID#: __________________

The problem for which you are seeing a Toledo Clinic physician may have occurred as a result of your employment. If your problem is ***not*** work related, please complete the declaration below. If your problem is due to an injury or disease that ***is*** work related, please complete the Bureau of Worker's Compensation form to follow. For coordination of benefits, the information in this form will be shared with your BWC provider and our billing department.

BUREAU OF WORKER'S COMPENSATION DECLARATION

PLEASE READ CAREFULLY: By signing this form, you are declaring that the injury or disease for which your Toledo Clinic physician is treating you ***IS NOT* an industrial injury and that it *DID NOT* occur while you were on the job or executing a work related activity.**

Patient Signature: ____ Date: ____________________

PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT

Medical Office Use Only

Diagnosis Code: ______________________________ *CPT Code:* ___________________________________

Date of Service: ______________________________ *Chart of Account #:* ____________________________

Physician: ___________________________________

BUREAU OF WORKER'S COMPENSATION DECLARATION

PLEASE READ CAREFULLY: By signing this form, you are declaring that the injury or disease for which your Toledo Clinic physician is treating you ***IS* an industrial injury and that it occurred while you were on the job or executing a work related activity.**

The initial office visit is the patient's responsibility. Payment for the visit is due and payable at the time of that visit.

PRIOR APPROVAL will have to be received from the Bureau of Workers' Compensation before any surgery and/or additional treatment can be carried out. Further, you understand that you are financially responsible to The Toledo for all charges.

I hereby declare that my injury is work related and I authorize The Toledo Clinic to submit a claim with complete information to my Workers' Compensation insurance carrier for covered services rendered by my physician. I authorize my Workers' Compensation insurance to issue payment checks directly to The Toledo Clinic for all payable services. I understand that I am financially responsible to The Toledo Clinic for all charges to the extent they are not covered by insurance, unless otherwise prohibited by applicable State of Ohio law.

Patient Signature: ____ Date: ____________________________

Patient Name (Printed): ____

Claim Number: ____ Date of Injury: _____________________

Employer at the time of the injury ____

Address of the Employer ____

Is your employer disputing the claim? _____ Yes _____ No Is your claim in litigation? _____ Yes _____ No

Name of WC person (Claim Representative) we may contact regarding your claim ______________________________

Phone Number ____

Brief description of how the injury occurred ____

____

Claims mailing address of your self-insured employer, state funded BWC, or MCO (Managed Care Organization). (NOTE: Call your intermediary to obtain this address as it is usually different from the regular mailing address.)
***Allowed Diagnosis Codes (NOTE: You must call 1.800.644.6292 and enter option 0. This will connect you to the operator at BWC who can give you your allowed diagnosis codes. The codes will be 3 to 5 digits in length with the first 3 digits before the decimal and the 4th and 5th digits after the decimal.)

1. ____________________ 3. ____________________ 5. ____________________

2. ____________________ 4. ____________________ 6. ____________________

Please write down each diagnosis code given by the operator. You may only have 1 diagnosis.

*You will be issued a 2" x 3" white and black Identification Card from BWC. You need to bring the card with you for your first appointment to see The Toledo Clinic physician. **You will also need to complete this form and bring it with you to your appointment.**

Health Insurance: ____ Patient's ID#: _____________________

Member's Name: ____ Member's ID#: ____________________

Medical Office Use Only

Diagnosis Code: _______________________________ *CPT Code:* __________________________________

Date of Service: _______________________________ *Chart of Account #:* ____________________________

Physician: ____________________________________