A Comprehensive Approach to Pain and Rehabilitation

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OMID MAHGEREFTEH, D.C.

Dear Patient, ________________________

Referred By Doctor, ____________________

Welcome to Universal Pain Management.

Your appointment date is: _________ **Please arrive at:** _______

You will be seen at:

☐ **819 Auto Center Drive** **Palmdale, Ca. 93551** **(661) 267-6876**	☐ **12830 Hesperia Road Ste B** **Victorville, Ca. 92395** **(760) 241-0350**	☐ **28212 Kelly Johnson Pkwy Ste 155** **Valencia Ca. 91355** **(661) 367-9788**

The Provider you will be seeing is:

☐Shahin Sadik, M.D, Q.M.E., ☐Francis X. Riegler, M.D., ☐Ray d'Amours, M.D., ☐Jae Jung, M.D.,

☐Daniel Alves, M.D., ☐Sue Alexander, M.N. F.N.P. ☐Elizabeth Tighe, F.N.P. ☐Rosana Budd, G.N.P.

☐ Jennifer Zubick, F.N.P. ☐ Christine Picker, M.S.N., F.N.P. ☐ Trudy Roberts, M.S.N., F.N.P.

Please bring the following in order to help us serve you better:

1. **Insurance card(s)**
2. **Co-payment** (if necessary)
3. **Authorization** (if necessary)
4. **Completed copy of the enclosed questionnaire**. (Please make sure packet is completely filled out and all consents are signed.)
5. **All medical records** (in order to create the best treatment plan for you, your provider will need to know as much as possible about you and your health).
6. **Completed copy of the patient information sheet.**
7. **Please read the patient information before coming to the office.** (See attached.)
8. **Please arrive on time or come early if you have questions or need assistance with your paperwork.**
 (These appointments are carefully arranged to ensure that all patients receive the highest standard of care and attention.)
We do encourage you to be prompt for your appointments, as a latecomer may affect the operation of the office.
Please understand if you are late you may be asked to reschedule to another day.
9. **If you can not keep your appointment**, (please give the office at least **72 hour notice** so that you may be given another appointment.)

Thank you for allowing us to take part in your care. We look forward to seeing you soon.

Sincerely,

Alma L. Vargas
New Patient Coordinator

819 Auto Center Drive • Palmdale, CA 93551 • 661-267-6876 • fax 661-538-9483
12830 Hesperia Road Suite "B" • Victorville, CA 92395 • 760-241-0350 • fax 760-243-0738
28212 Kelly Johnson Parkway Suite 155 • Valencia, CA 91355 • 661-367-9788 • fax 661-367-9789
www.UniversalPain.com

Universal Pain Management Center
Patient Information Form

Patient Last Name_______________ First Name_______________ Middle Initial___
Mailing Address_______________ City_______________ State_____ Zip_______
Home Address_______________ City_______________ State_____ Zip_______
Home Phone Number_______________ Work Phone Number_______________
Pager/Cell Phone Number _______________ Alternative Phone Number _______________
Email Address _______________
Birth Date__________ Social Security Number_______________ Sex: M / F Marital Status:_______

Primary Insurance Information:
Insurance Company Name_______________
Address_______________ Phone Number__________
Group/Policy Number_______________ Identification Number_______________
Guarantor Name_______________ Relationship to insured: Self Spouse Child Other
Guarantor's Birth Date__________ Guarantor's Social Security Number_______________ Sex: M / F

Secondary Insurance Information:
Insurance Company Name_______________
Address_______________ Phone Number__________
Group/Policy Number_______________ Identification Number_______________
Guarantor Name_______________ Relationship to insured: Self Spouse Child Other
Guarantor's Birth Date__________ Guarantor's Social Security Number_______________ Sex: M / F

Employer_______________
Universal Pain Management Provider you are seeing today_______________
Referring Physician (if any)_______________ Phone Number_______________
Primary Care Physician_______________ Phone Number_______________
Referring Patient (if any)_______________
Employment Status: [ ] Full Time [ ] Part Time [ ] Unemployed [ ] Retired

- Is this visit related to: [ ] Work Related Injury [ ] Auto Accident [ ] Personal Injury

If you checked any of the above, please fill out form 1a. If one was not provided to you, please ask the receptionist.

Person to be contacted in case of emergency_______________
Phone Number_______________ Relationship_______________

In signing this form you agree that all of the above is true and correct as of date signed. You also understand that we bill your insurance as a courtesy to our patients. If your insurance does not pay your claims for whatever reason, you understand that you are ultimately responsible for your bill. This does not apply to injury cases.

_______________________________ _______________
Patient or Patient Representative Signature Date

_______________________________ _______________
Witness Date

Universal Pain Management Medical Center
Workers Compensation Information

Patient: ____________________ Date: __________

Address: ____________________ Home Phone # __________

_____ Male _____ Female Date Of Birth: __________ Social Security # __________

Referral Source: ____________________ Phone # __________

Address: ____________________ Fax # __________

Primary Treating Physician For Workers Comp: ____________________

Address: ____________________

Phone # ____________________ Fax # __________

Claim # ____________________ **Date of Injury:** __________

Workers Compensation Company: ____________________

Address: ____________________

Phone # ____________________ Fax # __________

Employer at Time of Injury: ____________________

Address: ____________________

Phone # ____________________ Fax # __________

Claims Adjustor: ____________________

Address: ____________________

Phone # ____________________ Fax # __________

Medical Case Manager: ____________________

Address: ____________________

Phone # ____________________ Fax # __________

Utilization Review Deparment: ____________________

Address: ____________________

Phone # ____________________ Fax # __________

Patient's Attorney: ____________________

Address: ____________________

Phone # ____________________ Fax # __________

Defense Attorney: ____________________

Address: ____________________

Phone # ____________________ Fax # __________

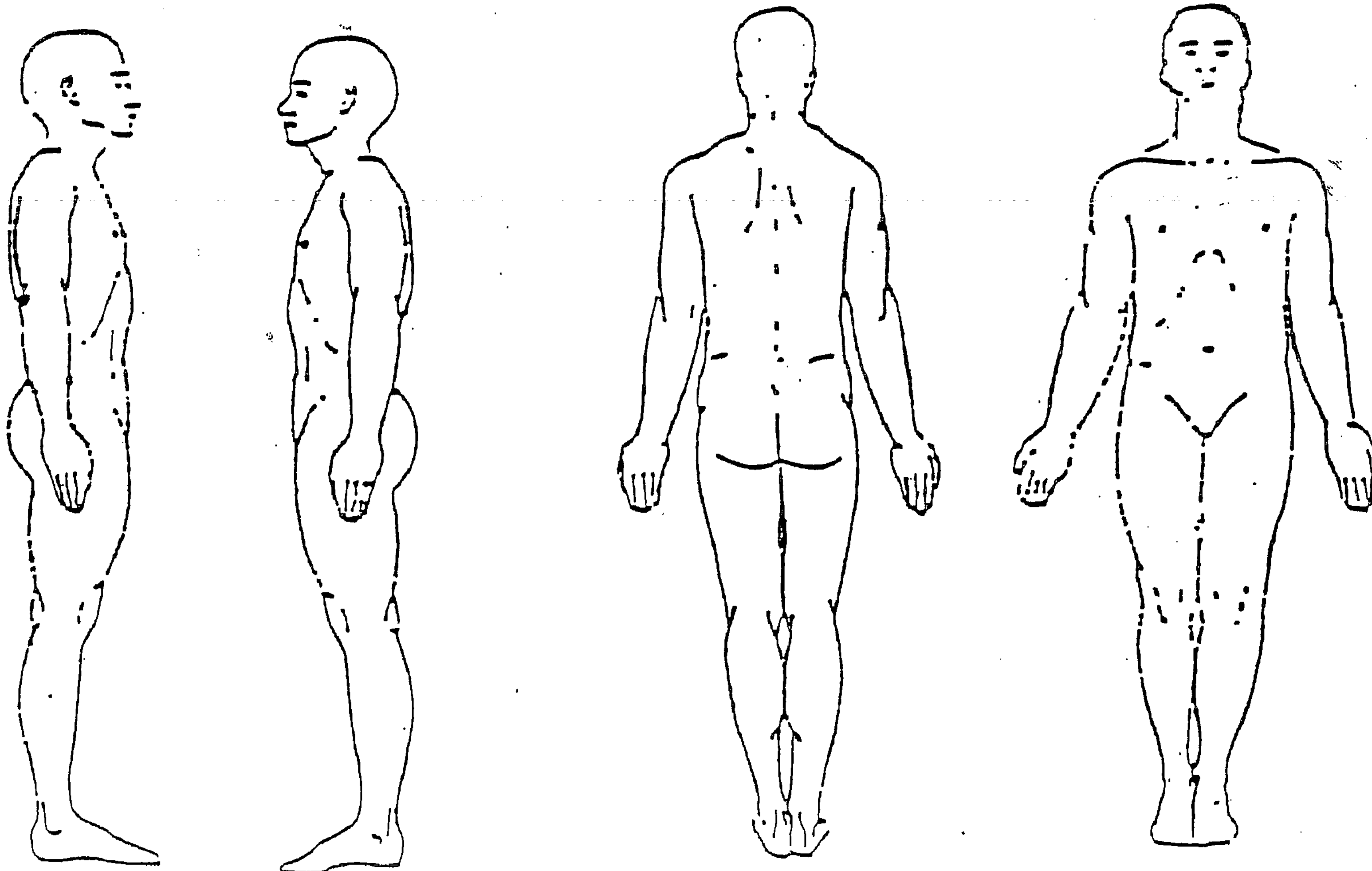
UNIVERSAL PAIN MANAGEMENT MEDICAL CENTER

Name:______________________________ Date:__________________________

Use the following scales to indicate how severe your pain is:

PAIN		NO PAIN									UNBEARABLE
A.	When at its LEAST:	0	2	3	4	5	6	7	8	9	10
B.	When at its WORST:	0	2	3	4	5	6	7	8	9	10
C.	At PRESENT:	0	2	3	4	5	6	7	8	9	10

Please indicate location(s) of your pain below:



UNIVERSAL PAIN MANAGEMENT MEDICAL CENTER
Initial Evaluation

How long have you had this pain? ______________________

Please circle the words that describe your pain:

ACHING	SHOOTING	DULL	CONSTANT
BURNING	TINGLING	TIGHT	RADIATING
CRAMPING	HOT	HEAVY	ANNOYING
NUMB	COLD	INTENSE	SEVERE
STINGING	SORE	TRANSIENT	EXCRUIATING

Please use a check mark to indicate if any of the following increases, decreases or causes no change in your pain?

	Increases Pain	Decreases Pain	No Change
Liquor	______	______	______
Coffee	______	______	______
Eating	______	______	______
Heat	______	______	______
Cold	______	______	______
Dampness	______	______	______
Weather Changes	______	______	______
Physical Activity	______	______	______
Massage	______	______	______
Movement	______	______	______
Sleep, Rest	______	______	______
Lying Down	______	______	______
Sitting	______	______	______
Walking	______	______	______
Sexual Intercourse	______	______	______
Standing	______	______	______
Distraction (TV etc.)	______	______	______
Urination	______	______	______
Bowel Movement	______	______	______
Tension or Stress	______	______	______
Bright Lights	______	______	______
Loud Noises	______	______	______
Fatigue	______	______	______
Sneezing or Coughing	______	______	______

UNIVERSAL PAIN MANAGEMENT MEDICAL CENTER
INITIAL EVALUATION

Have you had any operations for treatment of this problem?

TYPE OF OPERATION	DATE	RESULT

Please list all medications you are currently taking.

MEDICATION	REASON TAKEN	HOW OFTEN	DOCTOR

Please list medications you have tried for this problem but are no longer taking.

MEDICATION	BENEFIT: YES OR NO	DOSE	WHY STOPPED

UNIVERSAL PAIN MANAGEMENT MEDICAL CENTER
INITIAL EVALUATION

Please check any of the following treatments you have had for this pain problem. Include the approximate dates and the results.

TREATMENT	YES	PAIN RELIEF: YES NO	DATE DONE
NERVE BLOCKS	____	________	____________
EPIDURAL STEROIDS	____	________	____________
TENS UNIT	____	________	____________
PHYSICAL THERAPY	____	________	____________
TRACTION	____	________	____________
ACUPUNCTURE	____	________	____________
CHIROPRACTOR	____	________	____________
PAIN CLINIC	____	________	____________
PSYCHOLOGIST	____	________	____________
HYPNOSIS, BIO-FEEDBACK	____	________	____________
OTHER	____	________	____________
______________	____	________	____________
______________	____	________	____________

Are you allergic to any medicines or foods? Please describe.

____

____

Do you now, or have you ever had any other medical problems? (check each.)

DIABETES	____	EPILEPSY	____
HIGH BLOOD PRESSURE	____	SHINGLES	____
HEART DISEASE	____	BOWEL PROBLEMS	____
VASCULAR PROBLEMS	____	ARTHRITIS	____
ASTHMA	____	OTHER	____________
EMPHYSEMA	____	OTHER	____________
KIDNEY PROBLEMS	____	OTHER	____________
AIDS OR HIV	____	OTHER	____________
LIVER DISEASE	____	OTHER	____________
STROKE	____	OTHER	____________

UNIVERSAL PAIN MANAGEMENT MEDICAL CENTER
INITIAL EVALUATION

Do you use tobacco? __________ If yes how much? ____________________

Do you drink alcohol? __________ If yes how much? ____________________

Have you ever had a problem with abusing drugs or alcohol? ______________
If yes, please describe.

____

Has anyone in your family had any serious illnesses? Please describe.

____

____

____

Are you now taking, or have you ever taken anticoagulants or blood thinners, such as Coumadin or Warfarin?

____

How do you spend your time during the day?

____

____

____

Have you ever been convicted for abuse, possession, or sale of narcotics? If yes, please explain below.

____

____

____

Are you currently on disability?

____

Is it possible you could be pregnant?

____

UNIVERSAL PAIN MANAGEMENT MEDICAL CENTER
INITIAL EVALUATION

REVIEW OF SYSTEMS

Please circle any of the symptoms, disease or problems you have had recently.

RASH	FEVER
CHILLS	SWEATS
DIZZINESS	BLURRY VISION
CHANGE IN HEARING	SWOLLEN GLANDS
SORE THROAT	COUGH
SHORTNESS OF BREATH	CHEST PAIN
PALPITATIONS	NAUSEA
VOMITING	DIARRHEA
BLOOD IN STOOL	BLOOD IN URINE
COUGHING UP BLOOD	PAIN ON URINATION
LOSS OF BOWEL CONTROL	LOSS OF BLADDER CONTROL
WEAKNESS	NUMBNESS
UNUSUAL LOSS OR GAIN OF WEIGHT	EASY BRUISING OR BLEEDING
DIABETES	CANCER
ASTHMA	BRONCHITIS
HIGH BLOOD PRESSURE	SEIZURES
TUBERCULOSIS	HIV OR AIDS
STROKE	KIDNEY PROBLEMS

Have you traveled out of the country recently? If yes, where?

____

Have you been exposed to any known toxins?

____

Is there any additional information you think we should have?

____

____

____

UNIVERSAL PAIN MANAGEMENT MEDICAL CENTER
INITIAL EVALUATION

Please indicate any diagnostic tests you have had, and the approximate date and location where they were performed.

	YES	DATE	LOCATION
X-RAYS	____	______	____________________
EMG	____	______	____________________
CAT SCAN	____	______	____________________
MYELOGRAM	____	______	____________________
DISCOGRAM	____	______	____________________
MRI	____	______	____________________
OTHER	____	______	____________________

UNIVERSAL PAIN MANAGEMENT MEDICAL CENTER
Pain Disability Index

The rating series below are designed to measure the degrees to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain on your life, not just when the pain is at its worst.

For each category, please *circle the number* which describes the level of disability you typically experience. A score of "0" means no disability at all, and a score of "10" means that all the activities in which you would normally be involved in have been totally disrupted or prevented by your pain.

1. Family/home responsibilities. Activities related to the home or family, including chores and duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school.)

   0 1 2 3 4 5 6 7 8 9 10

   No Disability — Total Disability

2. Recreation. Hobbies, sports, and similar leisure time activities

   0 1 2 3 4 5 6 7 8 9 10

   No Disability — Total Disability

3. Social Activity. Participation with friends and acquaintances *other than family members* including theater, dining out, and other social functions.

   0 1 2 3 4 5 6 7 8 9 10

   No Disability — Total Disability

4. Occupation. Activities that are a part of or are directly related to one's including non-paying jobs such as that of a homemaker or volunteer work.

   0 1 2 3 4 5 6 7 8 9 10

   No Disability — Total Disability

5. Sexual activity. This category refers to the frequency and quality of one's sex life.

   0 1 2 3 4 5 6 7 8 9 10

   No Disability — Total Disability

6. Self Care. Activities of personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.).

   0 1 2 3 4 5 6 7 8 9 10

   No Disability — Total Disability

7. Life support activities. Basic life support behaviors such as eating, sleeping, and breathing.

   0 1 2 3 4 5 6 7 8 9 10

   Life Disability — Total Disability

Print Name: ______________________ Date: ______________

Signature: ______________________

UNIVERSAL PAIN MANAGEMENT MEDICAL CENTER
SHORT FORM MCGILL PAIN QUESTIONNAIRE

For each word that applies to your pain, rate the intensity of that particular quality of pain.

DESCRIPTION	(0) None	(1) Mild	(2) Moderate	(3) Severe
1. Throbbing	___	___	___	___
2. Shooting	___	___	___	___
3. Stabbing	___	___	___	___
4. Sharp	___	___	___	___
5. Cramping	___	___	___	___
6. Gnawing	___	___	___	___
7. Hot, Burning	___	___	___	___
8. Aching	___	___	___	___
9. Heavy	___	___	___	___
10. Splitting	___	___	___	___
11. Tiring-Exhausting	___	___	___	___
12. Sickening	___	___	___	___
13. Fearful	___	___	___	___
14. Punishing-Cruel	___	___	___	___

Rate the intensity of your pain overall:

0	No Pain	___
1	Mild	___
2	Discomfort	___
3	Distressing	___
4	Horrible	___
5	Excruciating	___

On the following line indicate the intensity of your pain overall:

No Pain ____ **Worse possible pain**

____
Print Name

______________________________ ______________
Signature **Date**

Universal Pain Mangement
Medical Center

NAME: ______ **DATE:** ______
AGE: ______ **SEX:** ______ **OCCUPATION:** ______

Please describe how you have felt during the PAST WEEK by placing a check (✓) in the appropriate box.
Do not think too long before answering.

	NOT AT ALL	A LITTLE/ SLIGHTLY	A GREAT DEAL/ QUITE A BIT	EXTREMELY/ COULD NOT HAVE BEEN WORSE
1. Feeling hot all over				
2. Sweating all over				
3. Dizziness				
4. Blurring of vision				
5. Feeling Faint				
6. Nausea				
7. Pain in Stomach				
8. Churning in Stomach				
9. Mouth becoming dry				
10. Neck muscles aching				
11. Legs feeling weak				
12. Muscles twitching & jumping				
13. Tense feelings across forehead				

SUBTOTAL:______

On the following, put a check (✓) in the box according to how it relates to you and your feelings during the PAST WEEK or so.

	NONE OR A LITTLE OF THE TIME	SOME OF THE TIME	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
1. I feel down-hearted, blue & sad				
2. Morning is when I feel the best				
3. I have crying spells or feel like it				
4. I have trouble sleeping through the night.				
5. I eat as much as I used to.				
6. I enjoy looking at, talking to and being with attractive women/men				
7. I notice that I am losing weight.				
8. I have trouble with constipation.				
9. My heart beat faster than usual.				
10. I get tired for no reason.				
11. My mind is as clear as it used to be.				
12. I find it easy to do the things I used to.				
13. I am restless and can't keep still.				
14. I feel hopeful about the future.				
15. I am more irritable than usual.				
16. I find it easy to make decisions.				
17. I feel that I am useful and needed.				
18. My life is pretty full.				
19. I feel that others would be better off if I were dead.				
20. I still enjoy the things I used to do.				

SUBTOTAL:______
TOTAL:______

DISPOSITION:______

UNIVERSAL PAIN MANAGEMENT MEDICAL CORPORATION

PATIENT NAME: ________________________________ **DATE:** ___________

READ CAREFULLY BEFORE SIGNING

1. **MEDICAL CONSENT** The patient is under the care of the attending physicians. The patient or the patient's representative consent to any medical treatments or procedures, including invasive procedures (upon special consent), x-ray examinations, taking of medical photographs and laboratory procedures.
2. **FINANCIAL AGREEMENT** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself to pay the account of the UNIVERSAL PAIN MANAGEMENT MEDICAL CENTER, and all treating physicians in accordance with the regular posted rates and the terms of the center/physicians. It is understood that the account is payable according to payment arrangements between the patient and the physician. Should the account be referred to an attorney or collection agency, the undersigned shall pay actual attorney's fees and collection expenses.
3. **ASSIGNMENT OF INSURANCE BENEFITS** I do hereby assign irrevocably to the above named medical facility, to the full extent permitted by law, all rights and benefits payable under any insurance policies providing coverage for medical services costs in an amount not to exceed the charges I incur to said medical center for services during the period of my treatment. I fully understand that I am primarily and financially responsible to the medical center/physicians for the charges in addition to those charges not paid for under the assignment, and in the event the money is due or the benefits are not paid within sixty (60) days from the date of the billing for payment, I will promptly make arrangements to pay the outstanding account.
4. **AUTHORIZATION TO RELEASE MEDICAL RECORDS** I do hereby give my permission and consent to release any and all medical records and x-rays, MRI reports, etc., to UNIVERSAL PAIN MANAGEMENT MEDICAL CENTER, upon request, and that these records be sent to the above-named facility within seven (7) days from the date of request.

______________________________	______________________________
Signature	**Witness**
______________________________	______________________________
Signature of Patient's Representative	**Relationship to Patient**
______________________________	______________________________
Financial Guarantor	**Name of Insurance Subscriber**

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR THE TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Patient Name: ______________________________ **Date:** ________________

Universal Pain Management Medical Corporation has implemented all the HIPPA (Health Insurance Portability and Accountability) guidelines recommended by the Federal Government. For more information, please ask to see our Notice Of Privacy Practices.

We have implemented the following to protect and safeguard your health information:

- Ongoing training for all our employees on privacy policy and procedures.
- Established safeguards to protect all electronically stored data.

Universal Pain Management Medical Corporation will only use your personal information for:

- Planning your care and treatment.
- Communicating with other health care professionals who may contribute to your care.
- Communicating with your insurance care provider.

We do request your permission to have a:

- Sign-in sheet at the front desk.
- To call out your name at the time of your appointment.

We will get your written permission if we were to use your personal information for any other reasons.

You have the right:

- To revoke this consent in writing, except to the extent that Universal Pain Management Medical Corporation has already taken action in reliance thereon.
- To inspect and copy your medical information.
- Get information about the disclosures we have made on your behalf.

Please outline any other restrictions that you would like us to place in the disclosure of your health information:

____

Please do not hesitate to contact our Privacy Officer, Lance Jackson at (661) 267-6876, Ext. 107 if you have any questions, concerns, or suggestions.

____ **Accepted** ____ **Denied**

____ **Date:** ____________________

Signature of Patient or Legal Representative Witness

____ **Date:** ____________________

Witness Signature

UNIVERSAL PAIN MANAGEMENT MEDICAL CORPORATION
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below. A copy of this signed form will be provided to the patient.

I hereby authorize (name of provider/address):

____

____

I hereby authorize any and all Pharmacies to release my prescription history.

To disclose the following information from the health records of:

Name:____
Last First MI Previous Name
Birthdate: ________________Social Security #:______________
Telephone: (H)________________(W)________________________

Address: ____
Street City State Zip

This information is to be disclosed to:

Universal Pain Management Medical Corporation

819 Auto Center Drive Palmdale, Ca. 93551

Phone (661-267-6876 Fax (661) 538-9483

Covering the periods of healthcare (Date(s) of service):

From (date)__________________________ to (date)______**Present**______

For the purpose of:____
(Not required if the disclosure is requested by the patient)

The following information may be released:
All information may be released____

____

TURN OVER ➜

UNIVERSAL PAIN MANAGEMENT MEDICAL CORPORATION
AUTHORIZATION FOR DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I understand that this will include information relating to **(check and initial, if applicable):**

- ☐ Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection.
- ☐ Behavioral health service/psychiatric care.
- ☐ Treatment for alcohol and/or drug abuse.

If compensation will be received: I understand that ____________________ will receive compensation for its use/disclosure of the information release pursuant to this authorization.
Patient's initials: ____________

Affirmation of Release:

I give ________ **See Front** ____________ or the named agency permission to release only the information I have selected on this form to the individual(s) or agency (ies) I have named and only for the purposes I have checked. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records during hospitalization and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations.

______________________________________   ________________________
Signature of the Patient/Guardian/Legal Representative   Date Signed

______________________________________   ________________________
Signature of Witness/Relationship to Patient   Date Signed

Expiration date: ______________________________
One year from date signed

TURN OVER ➔

UNIVERSAL PAIN MANAGEMENT MEDICAL CORPORATION
NARCOTIC USAGE CONTRACT

Patient Name: ________________________________

This policy is enacted to ensure the safe and proper use of <u>any</u> controlled substances.

Please Initial:

____1. Patient will provide physician with a complete and accurate history including past medical records, past pain treatments and hospitalizations, drug and alcohol use and drug abuse and addiction history.

____2. Patient agrees and gives permission for family members, significant others, roommates, healthcare professions and law enforcement officials to provide information for the purpose of obtaining information relevant to evaluating the efficacy, non-efficacy, side effects, or appropriateness of the medication prescribed.

____3. Patients must be seen regularly in the clinic, and may be asked for a urine sample for drug screening without notice, any visit and at any time.
FAILURE TO PROVIDE A URINE SAMPLE AT TIME OF REQUEST, WITHOUT LEAVING THE OFFICE, WILL CONSTITUTE GROUNDS FOR DISCHARGE FROM THIS CLINIC.

____4. Patients must receive narcotic prescriptions from only this physician's office which are to be filled at only one pharmacy. **The pharmacy name and phone number is:**________________
____

____5. Patient will inform MD of all noticed drug side effects and any concerns about the medication

____6. Patient will ***NOT*** take prescribed medication in ***ANY*** manner ***OTHER THAN*** as directed without first contacting the physician, as this would constitute reason for terminating the prescribing relationship. Furthermore, abuse of prescriptions will prompt notification of all pertinent area physicians and necessary legal authorities.

____7. Lost or stolen drugs or prescriptions will not be accepted as a reason for refill prior to the appropriate time period. This office ***AND*** local law enforcement agencies must be Notified of such loss or theft.

____8. This mode of ***TREATMENT WILL BE STOPPED IF*** *any* ***ONE*** of the following occurs:

- Patient hoards, gives, sells or misuses these controlled drugs or ***<u>any other</u>*** illegal drug.
- Patient develops rapid tolerance or loss of effectiveness from this treatment.
- Patient develops side effects that are significant in the view of the physician.
- Patient's functional activities decrease.
- Patient obtains any form of opiates or narcotics from sources other than the physicians in this office.

TURN OVER ➔

UNIVERSAL PAIN MANAGEMENT MEDICAL CORPORATION
NARCOTIC USAGE CONTRACT

Patient Name: ______________________________

Please Initial:

____9. Pregnancy may warrant discontinuance of opiate therapy at the discretion of the treating physician.

___10. If narcotic abuse occurs, the drug will be stopped /tapered immediately, and the patient agrees to enter a detoxification program if requested.

___11. Patient will not operate machinery or drive when feeling drowsy or when patient can expect to feel drowsy from medication, or at other times considered necessary at the discretion of the treating physician.

___12. Patient understands that the physicians of Universal Pain Management Medical Center will be reasonable but firm in interpreting all of the above policy statements.

REGARDING DRIVING OR USE OF HAZARDOUS MACHINERY: Pain medicine can decrease your alertness and thereby make certain activities such as driving more dangerous. You should take great care to avoid injury to yourself or others while taking these medicines. As each person responds differently to these medicines it is impossible for your physician to know what is a "safe dose" for you to take while driving. Some patients will be able to drive safely once they become accustomed to their medicines, but others will not. As with the use of alcohol, you must exercise careful personal judgment to determine in which activities you may safely participate while taking your medicines. In some cases it will become apparent to the physician that driving is not safe. In these cases the physician will advise you against driving. If necessary your physician will notify the Dept. of Motor Vehicles that driving privileges should be restricted.

THEREFORE, by my signature below, I affirm that I have read (or have had read to me) this Narcotic Usage Contract, understand it, and have had all questions answered satisfactorily, and thus, I (the patient) ***CONSENT TO THE USE OF OPIATES/NARCOTICS UNDER THE TERMS AS OUTLINED IN THIS AGREEMENT.***

Patient Signature:______________________________ Date:__________________

Witness Signature:______________________________ Date:__________________

TURN OVER ➔

Consent for Chronic Opioid Therapy

A consent form adapted from the American Academy of Pain Medicine

Dr. ______________________________ is prescribing opioid medicine, sometimes called narcotic analgesics, to me for a diagnosis of chronic pain:

This decision was made because my condition is serious or other treatments have not helped my pain.

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and likelihood that the medicine will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other possible treatments include non-opioid analgesics, interventional therapies and alternative medicine therapies.

I will tell my doctor about all other medicines and treatments that I am receiving.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

I am aware that certain other medicines such as nalbuphine (Nubain), pentazocine (Talwin), buprenorphine (Buprenex), and butorphanol (Stadol), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and 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.

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. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. 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.

(Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

(Females only) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines; the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

I have read this form or have it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines.

______________________________ ______________
Print Patient Name Date

______________________________ ______________
Patient Signature Date

______________________________ ______________
Witness Signature Date