

### Chronic Pain Management Consult Request Form

Use this form to request a Chronic Pain Consultation with a Pain Specialist. Include the following in your request.

- ✓ **This form**
- ✓ **History and physical**
- ✓ **Any other pertinent information**
- ✓ **Primary Care Provider signature (page 4)**

**Patient Information** (all fields are mandatory)

Patient Name \_\_\_\_\_  
Patient Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Patient Phone \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Gender: M [ ] F [ ]  
Medicaid ID# \_\_\_\_\_

**Referring Physician** (all fields are mandatory)

Name \_\_\_\_\_  
Provider Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_

**Diagnoses**

- 1.
- 2.
- 3.
- 4.
- 5.

**Office Use Only**

Secondary Insurance \_\_\_\_\_  
Medical Plan: [ ] FFS [ ] Molina [ ] Healthy U [ ] Select Access

**Reason for Referral - mark all that apply**

- Pain is chronic, 6 months or more duration.
- Concerned by narcotic co-prescribers.
- Desire for narcotic analgesia appears out of proportion to presenting symptoms and exam.
- Frequent visits for various subjective complaints; resulting in increased narcotic(s) utilization.
- Frequent lost, stolen or destroyed prescriptions.
- Frequent request for early refills.
- I need consultation that I am prescribing the appropriate medications.
- Other: \_\_\_\_\_

**Previous Treatment, Medications and Outcome**

Mark patient compliance and efficacy

	Efficacy Rating			
	None	Min	Avg	High
Treatments _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Assessment:**

1. Patient is medically stable.  Yes  No  
 How does the patient rate their pain on a scale of 0-10 (10 is highest)? \_\_\_\_\_

Indicate any **pending** medical evaluations.

	<i>Name of Provider</i>
<input type="checkbox"/> Neurology	_____
<input type="checkbox"/> Orthopedic surgery	_____
<input type="checkbox"/> Pulmonary	_____
<input type="checkbox"/> Ear, Nose, Throat	_____
<input type="checkbox"/> Infectious Disease	_____
<input type="checkbox"/> Oncology	_____
<input type="checkbox"/> Nephrology	_____
<input type="checkbox"/> Other	_____

Indicate any medical evaluations completed in the past 12 months:

<input type="checkbox"/> Neurology	_____
<input type="checkbox"/> Orthopedic surgery	_____
<input type="checkbox"/> Pulmonary	_____
<input type="checkbox"/> Ear, Nose, Throat	_____
<input type="checkbox"/> Infectious Disease	_____
<input type="checkbox"/> Oncology	_____
<input type="checkbox"/> Nephrology	_____
<input type="checkbox"/> Other	_____

Brief History: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Surgeries:(past or pending) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Laboratory/Radiology Results \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pain is result of:  
 herpes  
 reflex sympathetic dystrophy  
 acute back pain

2. Patient is mentally stable.  Yes  No  
If no, list any pending mental health evaluations and mental health provider.

Mental Health Provider \_\_\_\_\_ Mental Health phone # \_\_\_\_\_  
If diagnosis is available, please list: \_\_\_\_\_

Does/should this patient receive substance abuse or addiction treatment?  Yes  No

Is this patient in a Methadone treatment program?  Yes  No

Brief Mental History: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Did you initiate opioid therapy?  Yes  No

4. Does this patient have pain which is significantly reduced by opioids?  Yes  No

5. If the pain is neuropathic in origin, has the patient had adequate trials of drugs for neuropathic pain at the adequate dosage levels such as?

Neurontin: Dosage \_\_\_\_\_

Gabital: Dosage \_\_\_\_\_

Topamax: Dosage \_\_\_\_\_

other neuropathic medication and dosage: \_\_\_\_\_

6. Have increased dosage(s) of pain medication resulted in long term improvement in pain and/or function?

Yes  No

If Yes, describe the improvement and length of time of the improvement? \_\_\_\_\_

7. Have alternatives to medications for pain relief been tried?  Yes  No

relaxation

physical therapy

occupational therapy

hypnosis

meditation

biofeedback

acupuncture

other: \_\_\_\_\_

8. This person:

has sleep problems

has been evaluated for sleep problems

- is taking sleep medications
- does not have a sleep problem

Comments: \_\_\_\_\_  
\_\_\_\_\_

9. This person has a history of :

- lost medications
- overuse of opioids
- stolen medications
- chronic aggressive or violent behavior
- requesting early refills
- getting medications from multiple providers
- diverting medications
- overdose/suicide attempt

10. This patient has history of:

- nicotine use: packs per day \_\_\_\_\_
- alcohol use:  daily  1-2 days/wk  1-2 days/mon  less than 1-2 days/mon  
Type: \_\_\_\_\_ Amount: \_\_\_\_\_
- psychotropic prescription drugs: \_\_\_\_\_
- illegal drugs:  marijuana  cocaine  heroin  other narcotics  
Type: \_\_\_\_\_  
Amount: \_\_\_\_\_
- long standing behavioral problems
- use of herbal medications
- numerous attempts at treatment
- dizziness, blackouts, disorientation
- falls, bruises, burns, poor hygiene
- seizures, memory loss, incontinence
- anxiety, headaches, depression, functional decline
- pain interferes with client's ability to remain functional and independent

11. This person has recently experienced:

- death of spouse, parent or child
- physical impairment or disability
- diminished social/family support
- social isolation
- financial problems
- retirement
- divorce
- other \_\_\_\_\_

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PHYSICIAN/ PROVIDER CERTIFICATION**

***Approval for a Chronic Pain Consult requires involvement of the Primary Care Provider (PCP).***

**I agree to serve as the primary care provider. I agree to coordinate the treatment plan with the Pain Center and will resume prescribing responsibility at the end of the evaluation.**

**PCP Name \_\_\_\_\_ PCP Phone \_\_\_\_\_**