Edgerton HOSPITAL AND HEALTH SERVICES

Pain & Spine Center
11101 N Sherman Rd. Edgerton, WI, 53534
Phone: 608-561-6614 ext. 3 Fax: 608-561-6616

Patient Label

Dear Patient:

Welcome to Edgerton Hospital Pain Management Center! Thank you for choosing our pain management program for your treatment. We are committed to providing our patients and community with balanced, safe, and effective pain management care.

Please review and complete the entire packet prior to your visit to ensure you are aware of our expectations.

APPOINTMENT EXPECTATIONS:

- Please note that it is your responsibility to check with your insurance company prior to your initial visit to check your pain management benefits. If a referral is required, it is your responsibility to contact your primary care provider (PCP), or referring provider, to request a referral. Referral may be faxed to the above number.
- Please give a 24-hour advance notice for cancellations. If you do not show for your appointment, you may be discharged from the practice.

TREATMENT PLAN:

- You will be asked to provide a urine sample as part of your first clinic visit to help guide treatment plan.
- The provider will work with you to diagnose your pain condition and create an individualized, balanced care plan designed specifically for you. Through our tailored care plan, we will work with you to provide treatment options to deliver long-term relief from pain that is hindering your daily life.
- Our providers prescribe medications at their discretion and may not be prescribed during your first visit, or subsequent visits.
    - Patients prescribed pain medication will be subject to random urine drug tests. Failure to comply will result in termination from the practice.
- To provide treatment, you must be seen by your PCP every 12 months, if you do not currently have a PCP you will need to establish with one to continue treatment.
- All patients are required to complete a pain treatment agreement, even if medications are not prescribed.
- We kindly ask all patients to create and utilize a MyChart account as this will help ensure messages and information can be sent and received timely. If you do not already have a MyChart account you can create one by going to: https://mychart.ssmhc.com

PRESCRIPTIONS AND RENEWALS:

- All prescription refill requests must be requested during normal office hours, Monday through Friday 8a-4p. Please give a 10-day notice for all refill requests. Refills will not be addressed after business hours, on weekends, or holidays.
- Please allow 7 – 10 business days for all prescription refills. Urgent/last minute requests for refills will not be tolerated.

(continued)

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FINANCIAL POLICY:

- The Pain Management Center is a department of Edgerton Hospital & Health Services, you will receive a bill from the hospital which includes a facility charge, support staff, supplies and/or pharmacy charges.
- You will also receive a bill from the Physician's billing company, which includes charges for the Physician's professional services. Please contact the billing company for any questions or concerns with your professional bill.
- It is your responsibility to check your individual insurance policy regarding the physician's participation in your plan and co-payment policies. All unpaid balances by your insurance company will be billed to you.

All the best,

Dr. Arpan Patel and the Pain Management Center Staff
608-561-6614 ext 3

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Patient Name: _____ **DOB**: _____

Referring Physician: _____
Primary Care Physician: _____
Note: **REQUIRED to be seen by PCP every 12 months. If you do not have a PCP, you will need to establish with one**

Complaint: _____ **Began**: _____ **Avg Pain Score (0-10)**: _____

Location: Upper Back Lower Back Head Neck Arms Hands Feet Other: _____

Pain Travels To: Left Arm Right Arm Left Leg Right Leg Other: _____

Pain Quality: Constant Intermittent Sharp Dull Burning Throbbing Shooting Tingling
Other: _____

What makes it worse: Walking Standing Sitting Bending Fwds Bending Bkwds Activity AM/PM Laying

What makes it better: Walking Standing Sitting Bending Fwds Bending Bkwds Ice Heat Massage Laying

Numbness: No Yes Where: _____ **Weakness**: No Yes Where: _____

Loss of control of your bowel or bladder: No Yes

What Imaging Studies have you had: MRI CT X-Ray EMG Bone Scan
Where? _____

Prior/Current Treatment	Relief? **Yes**	**No**	When / How Often
Injection (type):			
Pain Physician:			
Surgery (type):			
Chiropractic:			
Physical Therapy / TENS / Aquatics / Exercise			
Medications:			
Other (dry needle, massage, etc.):			

Physical Therapy: No Yes **Fully Completed**: No Yes **When**: _____
# of Sessions: _____

Medical History: High Blood Pressure Heart Attack Heart Failure Murmur Recent Cold/Cough Asthma Bronchitis Liver Problems Kidney Problems Diabetes Thyroid Problems Seizure Stroke Fainting Cancer Prolong Bleeding
Other: _____

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Patient Name: _____ **DOB**: _____

Surgical History with dates:

_____

_____

_____

Family History: Chronic Pain Depression Anxiety **Relationship to you:** _____

Currently Working: No Yes **Occupation:** _____ **Last day of work**: _____

Smoke History: No Yes **How many Packs/Day**: _____ **How many years**: _____ **When Quit**: _____

Alcohol History: None Socially Excessive

Substance Abuse: No Yes **Type**: _____ **When Quit**: _____

Office use only:
☐ BMI > 25kg/m2 ☐ BMI <18kg/m2 ☐ Depression F/U needed ☐ Tobacco cessation needed ☐ Alcohol counseling needed

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number
for each situation.

0 = WOULD NEVER DOZE
1 = SLIGHT CHANCE OF DOZING
2 = MODERATE CHANCE OF DOZING
3 = HIGH CHANCE OF DOZING

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in a public place (ie, at a play)	
As a car passenger for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total Score (score greater than 10 consider referral to sleep medicine)	

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By signing below I acknowledge and understand:

- I must have an established relationship with a primary care provider (PCP) and see my PCP at least every 12months. If I have not been seen by a PCP within the past 12 months, I will schedule a visit prior to my next pain management appointment.
- Medication prescriptions are at the discretion of the treating provider, medications will not be prescribed until non-pharmacological treatment options have been pursued.

Patient Signature: _____ **Date**: _____

We anticipate you will be pleased with your experience in our pain management center. Since people trust the experience of others, reviews and testimonials reassure and encourage prospective clients to choose Edgerton Hospital and Health Services for their pain management needs, we are looking for individuals who would be willing to share their experience. If you would be willing to consider participating, please indicate below.

☐ Yes, I would be willing to consider leaving a short review based on my experience with Edgerton Hospital and Health Services. The best way to contact me is:

☐ Phone: _____ ☐ Email: _____

☐ Not at this time

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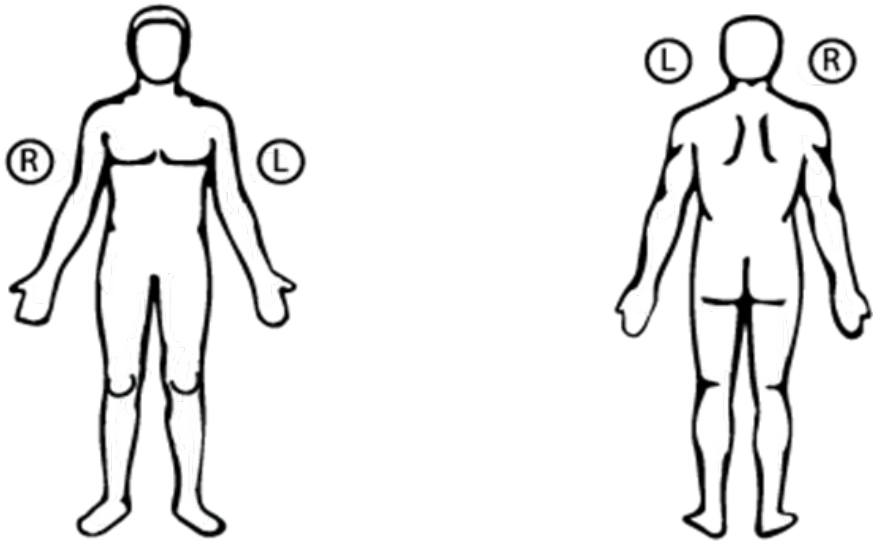
Patient Name: _____ **DOB**: _____

Review of Systems

Fever	**No**	**Yes**	Neck Pain	**No**	**Yes**
Fatigue	**No**	**Yes**	Back Pain	**No**	**Yes**
Blurred Vision	**No**	**Yes**	Joint Pain	**No**	**Yes**
Eye Pain	**No**	**Yes**	Weakness	**No**	**Yes**
Trouble Hearing	**No**	**Yes**	Headaches	**No**	**Yes**
Loss of Balance	**No**	**Yes**	Seizures	**No**	**Yes**
Irregular Heartbeat	**No**	**Yes**	Tingling/ Pins & Needles	**No**	**Yes**
Fainting	**No**	**Yes**	Trouble Sleeping	**No**	**Yes**
Trouble Breathing	**No**	**Yes**	Anxiety	**No**	**Yes**
Coughing up Blood	**No**	**Yes**	Abnormal Bleeding	**No**	**Yes**
Chronic Cough	**No**	**Yes**	Anemia	**No**	**Yes**
Heart Burn	**No**	**Yes**	Medication Allergy	**No**	**Yes**
Abdominal Pain	**No**	**Yes**	Latex Allergy	**No**	**Yes**
Vomiting or Nausea	**No**	**Yes**	Excessive Urination	**No**	**Yes**
Constipation	**No**	**Yes**	Pain on Urination	**No**	**Yes**

Draw your pain location on diagram



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SOAPP® Version 1.0-14Q

The following are some questions given to all patients at the Pain Management Center. Please answer each question as honestly as possible. Your answers alone will not determine your treatment.

Please answer the questions below using the following scale:

0= Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

	Never	Seldom	Some times	Often	Very Often
1. How often do you have mood swings?	0	1	2	3	4
2. How often do you smoke a cigarette within an hour after you wake up?	0	1	2	3	4
3. How often have any of your family members including parents and grandparents, had a problem with alcohol or drugs?	0	1	2	3	4
4. How often have any of your close friends has a problem with drugs or alcohol?	0	1	2	3	4
5. How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
6. How often have you attended an AA or NA meeting?	0	1	2	3	4
7. How often have you taken medication other than the way that it was prescribed?	0	1	2	3	4
8. How often have you been treated for an alcohol or drug problem?	0	1	2	3	4
9. How often have your medications been lost or stolen?	0	1	2	3	4
10. How often have others expressed concern over your use of medication?	0	1	2	3	4
11. How often have you felt a craving for medication?	0	1	2	3	4
12. How often have you been asked to give a urine screen for substance abuse?	0	1	2	3	4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0	1	2	3	4
14. How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4

Please include any additional information you wish about the above answers.

Total Points = _____

Reviewed 09.2022

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Patient Name: _____ **DOB**: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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 fidgety 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 in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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**
☐	☐	☐	☐

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Patient Name: _____ **DOB**: _____

AUDIT-C

Questions	**0**	**1**	**2**	**3**	**4**	**Score**
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total	

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Pain Treatment Agreement

This Agreement between _____ **(**"Patient") and the pain management provider is to begin an agreement outlining clear expectations for participation in the pain management program.

The Patient agrees to the following:

I understand that lowering my pain levels and improving my quality of life are goals of this program

_____ **(Initials)** I realize that it is my responsibility to take my medication safely and I should not drive while taking pain medication or other medications prescribed to me that may make me drowsy or less alert.

_____ **(Initials)** I agree that refills of my prescriptions of pain medicine will be made only at the time of an office visit or during regular office hours. I agree to give at least 7 business days' notice for refill requests. No refills will be available during evenings or on weekends.

_____ **(Initials)** I will not use any illegal controlled substances, including marijuana, cocaine, etc.

_____ **(Initials)** I authorize my pain provider to speak with my other treating practitioners concerning my condition or treatment.

_____ **(Initials)** I understand my pain medication dosage may be tapered if not effective

_____ **(Initials)** I understand that if I use medical or recreational marijuana, I will not be prescribed any opioids.

_____ **(Initials)** I agree not to take all mind/mood altering/illicit/addicting drugs including alcohol and Benzodiazepines unless authorized by this pain center provider.

I understand that my pain medication dosage may be tapered if not effective.

_____ **(Initials)** I will not share, sell, or trade my medication for money, goods, or services**.**

_____ **(Initials)** I will get all pain medication from ONLY ONE health care provider. **I WILL DISCONTINUE AND DISPOSE OF ALL PREVIOUSLY USED PAIN MEDICATIONS UNLESS TOLD TO CONTINUE THEM.**

I authorize my pain provider to speak with my other treating practitioners concerning my condition or treatment.

_____ **(Initials)** I will keep my medication safe from loss and theft and understand if I fail to do so I may no longer be prescribed pain medication.

_____ **(Initials)** I agree to use (name of 1 Pharmacy**)** _____located in _____, Telephone number_____**,** for all of my pain medication. If I change pharmacies for any reason, I agree to notify the provider at the time I receive a prescription.

_____ **(Initials)** I authorize the provider and pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the board of pharmacy in any investigations of any possible misuse, sale or potential medication diversion cases**.**

_____ **(Initials)** I agree that I will submit to a blood, saliva or urine test if requested by pain provider**.**

_____ **(Initials)** I understand that the use of CBD products may contain low levels of THC (the primary compound in marijuana) that may be revealed in my urinalysis and I will not be a candidate for opioid medication. Examples of CBD products may include but are not limited to: oils, lotions, gummies, edibles, capsules, etc.

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_____ **(Initials)** I agree that I will use my medication as prescribed by my pain provider. Overtaking my medication may result in the medication being discontinued.

_____ **(Initials)** I will bring all unused pain medication to be counted whenever requested**.**

_____ **(Initials)** I agree that one missed appointment or cancellation may lead to being discharged from the pain practice.

_____ **(Initials)** **I will treat the staff at the office/hospital respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.**

_____ **(Initials)** I agree to follow the care plan prescribed by my pain provider including Physical Therapy and behavioral health referrals if recommended.

SAFETY RISKS WHILE UNDER THE INFLUENCE OF OPIOID MEDICATIONS: There are potential adverse effects of opioid medications that are potentially dangerous. These include delayed reaction time, impaired judgment, drowsiness, physical addiction. Any of these may impair your ability to drive or operate heavy machinery. These adverse effects tend to diminish over time. ADVERSE EFFECTS OF OPIOID MEDICATIONS: These adverse effects may be made worse when mixing opioid medications with other medications, including alcohol! • Feelings of anxiety • Slowed or difficult breathing • Slow heart rate • Confusion • Constipation • Excess sweating • Dizziness or drowsiness • Nausea • Difficulty urinating • Impaired judgment • Vomiting • Physical or psychological dependence RISKS • Physical dependence. This means that abruptly stopping the medication may lead to withdrawal symptoms which may include: - Runny nose - Difficulty sleeping for several days - Diarrhea - Abdominal cramps - Sweating - Shakes and chills - Rapid heart rate - Nervousness

- (**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 medications; 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.

Doctor and Patient agree that this Agreement is essential to the Doctor's ability to treat the Patient's pain effectively and that ***failure of the Patient to abide by the terms of this Agreement*** *will result in corrective adjustments to the treatment plan and* ***may result in the withdrawal of all prescribed medication by the Doctor, possibly causing Patient to experience withdrawal symptoms, and the termination of the Doctor-Patient relationship.***

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Have you read and do you understand this document? (Initial one)

____ I was satisfied with the above description and did not want any more information.

____ I requested and received further explanation about the treatment, alternatives, or risks.

I agree to follow the terms of this agreement and I understand the risks, alternatives, and additional therapy associated with the use of controlled substances to treat my pain. I understand this document will be maintained as a permanent component of my chart.

Patient Signature _____ Date_____ Time_____

Staff Signature _____ Date_____ Time_____

Provider Signature_____ Date_____ Time_____

You will get a copy of this form and we will keep a copy of it in your patient file.