Hartford Hospital
A Hartford HealthCare Partner

Pain Treatment Center

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

_____

I authorize medical information to be released to my health insurance carrier including Medicare/CMS for payment of services rendered.

_____ _____

Signature of Patient or Legal Representative Witness Date Notice Effective Date or Version

❑ Accepted ❑ Denied Signature: _____

Date: _____

PATIENT NAME:_____ DOB:_____ DATE OF SERVICE:_____

Hartford Hospital
A Hartford HealthCare Partner

Pain Treatment Center

PATIENT NAME:_____
DOB:_____

NEW PATIENT QUESTIONNAIRE

PRIMARY CARE PHYSICIAN_____ PHONE_____

YOUR PHARMACY _____
NAME ADDRESS

MAILORDER PHARMACY (if applicable) _____

REFERRING PHYSICIAN_____ PHONE_____

SECTION 1: HISTORY OF PRESENT ILLNESS

ARE YOU INVOLVED IN ANY COURT CASES OR LAWSUITS? ❑ YES ❑ NO

IF YOURS IS A WORKERS' COMPENSATION CLAIM, IS YOUR CASE IN DISPUTE? ❑ YES ❑ NO

AS BEST AS YOU UNDERSTAND, WHY DID YOUR REFERRING PHYSICIAN SEND YOU TO OUR CLINIC?

_____

PLEASE CHOOSE ONE OF THE FOLLOWING: ❑ Right Handed ❑ Left Handed ❑ Ambidextrous

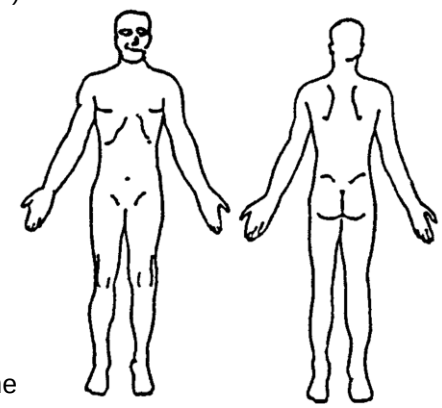
WORK STATUS: ❑Full Time ❑Part Time (___hrs/wk) ❑Not currently employed ❑Retired ❑Worker's Comp ❑Disability

OCCUPATION: _____

WHO ACCOMPANIED YOU TO TODAY'S APPOINTMENT? ❑ Alone ❑ Spouse ❑ Child ❑ Parent ❑ Other:_____

WHERE IS YOUR PAIN PRIMARILY LOCATED? (Please ☑ below & shade on diagram.)

❑ Head ❑ Neck ❑ Upper-Mid Back
❑ Right Arm ❑ Left Arm ❑ Mid-Back Pain
❑ Lower Back ❑ Abdomen ❑ Pain in the Tailbone
❑ Other:_____



HOW WOULD YOU DESCRIBE YOUR PAIN? (Please ☑ below all that apply.)

❑ Burning ❑ Shooting ❑ Throbbing
❑ Cramping ❑ Aching ❑ Constant
❑ Sharp ❑ Dull ❑ Intermittent
❑ Other: _____

PAIN INCREASES WITH: ❑ Walking ❑ Sitting ❑ Standing ❑ Activity ❑ Othe

PAIN DECREASES WITH: ❑ Rest ❑ Lying Down ❑ Heat ❑ Cold ❑ Other:_____

DO YOU USE ANY ASSISTIVE DEVICES? ❑ None ❑ Wheelchair ❑ Cane ❑ Walker ❑ Crutches ❑ Prosthesis ❑ Other

HOW WELL DO YOU SLEEP? ❑ 0-4 hrs/night ❑ 4-6 hrs/night ❑ 6-8 hrs/night
❑ Restful ❑ Disruptive ❑ Pain Related

SECTION 2: ACTIVE MEDICAL PROBLEMS (Please ☑ below any medical problem for which you are currently being treated.)

❑ High Blood Pressure ❑ Heart Attack ❑ Hearing Problems
❑ Diabetes or High Blood Sugar ❑ Cancer ❑ Vision Problems
❑ Angina or Chest Pain at Rest ❑ Chronic Cough ❑ High Cholesterol
❑ Angina or Chest Pain with Activity ❑ Arthritis ❑ Fainting Spells/Blackouts
❑ Ulcers/Gastrointestinal Problems ❑ On Dialysis ❑ Autoimmune Disease
❑ Bleeding problems ❑ TIA or Stroke ❑ Seizure or Epilepsy
❑ Bowel Incontinence ❑ Liver Disease ❑ Asthma / Wheezing
❑ Bladder Incontinence ❑ Kidney Disease ❑ Other_____

SECTION 3: PAST MEDICAL PROBLEMS (Please ☑ any medical problem that was diagnosed in the past and/or resolved.)

- ❑ High Blood Pressure
- ❑ Diabetes or High Blood Sugar
- ❑ Angina or Chest Pain at Rest
- ❑ Angina or Chest Pain with Activity
- ❑ Ulcers/Gastrointestinal Problems
- ❑ Bleeding problems
- ❑ Bowel Incontinence
- ❑ Bladder Incontinence
- ❑ Heart Attack
- ❑ Cancer
- ❑ Chronic Cough
- ❑ Arthritis
- ❑ On Dialysis
- ❑ TIA or Stroke
- ❑ Liver Disease
- ❑ Kidney Disease
- ❑ Hearing Problems
- ❑ Vision Problems
- ❑ High Cholesterol
- ❑ Fainting Spells/Blackouts
- ❑ Autoimmune Disease
- ❑ Seizure or Epilepsy
- ❑ Asthma / Wheezing
- ❑ Other_____

SECTION 4: SURGICAL PROBLEMS

LIST PAST SURGERIES AND THE DATES THEY WERE PERFORMED.

SURGERY	DATE	SURGERY	DATE

SECTION 5: ALLERGIES

HAVE YOU EVER BEEN TOLD THAT YOU HAVE AN ALLERGY TO A MEDICINE? ❑ YES ❑ NO

MEDICATIONS – ALLERGIC TO	REACTION

SECTION 6: MEDICATIONS (List all current medications, doses & frequencies, including over-the-counter medications & vitamins.)

MEDICATIONS			MEDICATIONS		
NAME	DOSE	FREQUENCY (How you take it)	NAME	DOSE	FREQUENCY (How you take it)

DO YOU TAKE ANY BLOOD THINNERS LIKE **COUMADIN, PLAVIX, LOVENOX** OR **ASPIRIN**? ❑ YES ❑ NO

PLEASE LIST ANY **PREVIOUS** MEDICATIONS, INJECTIONS, PHYSICAL THERAPY, TENS, AND CHIROPRACTICS TRIED.

MEDICATIONS	DATE	INJECTIONS	DATE
		TENS (Transcutaneous Electrical Nerve Stimulation)	**DATE**
PHYSICAL THERAPY	**DATE**	**CHIROPRACTICS**	**DATE**

SECTION 7: FAMILY HISTORY

HAS ANYONE IN YOUR FAMILY EVER HAD ANY OF THE FOLLOWING CONDITIONS? (Please check all that apply.)

	FATHER	MOTHER	BROTHER	SISTER	GRANDPARENT
Anxiety	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Chronic Pain	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Physical Disability	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Suicide	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐

SECTION 8: SOCIAL HISTORY

HOW MANY DAYS PER MONTH DO YOU TAKE OFF FROM WORK BECAUSE OF PAIN? _____

HAVE YOU EVER USED TOBACCO? ❑ YES ❑ NO DO YOU CURRENTLY SMOKE? ❑ YES ❑ NO

IF YES, HOW MANY PACKS PER DAY? _____ FOR HOW MANY YEARS? _____

DO YOU DRINK ALCOHOL? ❑ YES ❑ NO HOW MANY DRINKS/WEEK? _____

HAVE YOU EVER USED STREET DRUGS? ❑ YES ❑ NO DO YOU CURRENTLY USE STREET DRUGS? _____

CHECK THE ONES THAT YOU HAVE USED. ❑ MARIJUANA ❑ COCAINE ❑ METH ❑ HEROIN ❑ CRACK

MARITAL STATUS: ❑ MARRIED (# OF YEARS ____) ❑ DIVORCED (# OF YEARS ____) ❑ SINGLE ❑ WIDOW(ER)

CHILDREN? ❑ YES ❑ NO (# OF CHILDREN:_____ AGES: _____)

ANY RECENT STUDIES:

SECTION 9: CURRENT SYMPTOMS (Please indicate Yes or No for each symptom.)

Constitutional

Y N Fever	Y N Feeling Weak	Y N Recent Weight Gain (___ Lbs)
Y N Chills	Y N Feeling Tired (Fatigue)	Y N Recent Weight Loss (___ Lbs)
Y N Feeling Poorly (Malaise)	Y N Change In Appetite	

Eyes

Y N Vision Loss	Y N Eye Pain	Y N Discharge From Eyes
Y N Blurred Vision	Y N Dry Eyes	

ENT

Y N Earache	Y N Nosebleeds	Y N Sore Throat
Y N Loss of Hearing	Y N Nasal Discharge	Y N Hoarseness
Y N Post Nasal Drip	Y N *Sinus Stuffiness*	Y N *Difficulty Swallowing*

Cardiovascular

Y N Chest Pain	Y N Heart Rate is Slow	Y N Lower Extremity Swelling (Edema)
Y N Palpitations	Y N Leg Pain with Exercise (Leg Claudication)	
Y N Heart Rate is Fast		

Respiratory

Y N Shortness of Breath	Y N Cough	Y N Short of Breath on Exertion
Y N Wheezing	Y N Cough Worse at Night	Y N Need pillows to breathe (Orthopnea)

Gastrointestinal

Y N Abdominal Pain	Y N Vomiting	Y N Bloody Stools
Y N Constipation	Y N Diarrhea	Y N Heartburn/Acid Reflux
Y N Nausea		

Genitourinary

Y N Painful Urination (Dysuria)	Y N Incontinence	Y N Frequency
Y N Urinary Retention	Y N Urination Hesitancy	Y N Pelvic Pain
Y N Vaginal Discharge	Y N Abnormal Vaginal Bleeding	Y N Menstrual Pain (Dysmenorrhea)
Y N Genital Lesion	Y N Inadequate Penile Erection	

Musculoskeletal

Y N Joint Pain (Arthralgias)	Y N Neck Pain	Y N Limb Pain
Y N Muscle Pain (Myalgias)	Y N Joint Swelling	Y N Limb Swelling
Y N Back Pain	Y N Joint Stiffness	

Integumentary

Y N Skin Rash	Y N Itching (Pruritus)	Y N Hair Loss
Y N Hives	Y N Dry Skin	Y N Skin Wound(s)

(CONTINUED ON NEXT PAGE)

SECTION 9: CURRENT SYMPTOMS (CONTINUED) (Please indicated Yes or No for each symptom.)

Neurological

Y N Headache	Y N Numbness	Y N Fainting
Y N Confusion	Y N Tingling	Y N Limb Weakness
Y N Convulsions	Y N Tremor	Y N Difficulty Walking
Y N Significant Head Injury	Y N Dizziness	Y N Balance Impaired
Y N Memory Lapses/Loss	Y N Excessive Sleepiness During the Day (Daytime Somnolence)	

Psychiatric

Y N Suicidal	Y N Anxiety	Y N Depression
Y N Sleep Disturbances	Y N Crying Spells	Y N Emotional Problems

Endocrine

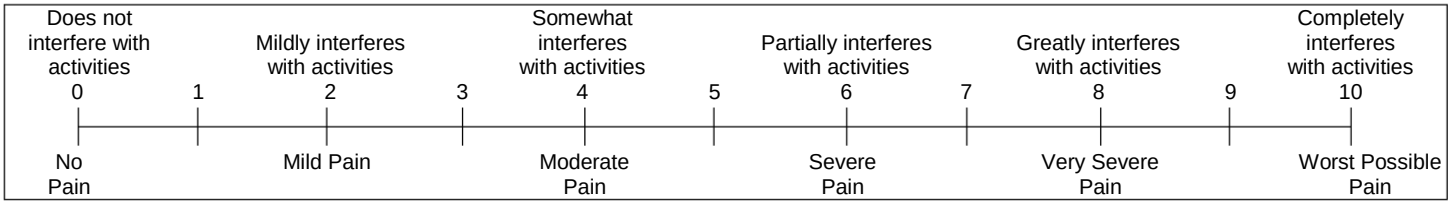
Y N Hot Flashes	Y N Deepening of the Voice
Y N Excessive Sweating	Y N Excessive Thirst (Polydipsia)

Heme/Lymph

Y N Swollen Glands	Y N Easy Bruising

SECTION 10: VITALS HEIGHT:_____ WEIGHT:_____

Using the chart below, answer each question by circling the number that corresponds with your pain level.



PAIN SCALE ⇨	☺	0	1	2	3	4	5	6	7	8	9	10	☹
Current pain level.	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
Average pain level since last visit.	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
Pain level at its worst.	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
Pain level at its least.	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
Rate your ability to:													
Sleep	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
Manage activities that require standing	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
Manage activities that require walking	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
Manage activities that require sitting	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
Manage your daily responsibilities	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
Manage your hobbies and/or recreational activities.	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
Choosing <u>one</u> from the following activities, rate your ability to do:_____	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes

① work ③ gardening/yard work ⑤ driving ⑦ sports/golf
② housework ④ play with children ⑥ exercise ⑧ intimacy

SCL-90-R®

INSTRUCTIONS:

Below is a list of problems people sometimes have. Please read each one carefully, and circle the number to the right that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Circle only one number for each problem and do not skip any items. If you change your mind, erase your first mark carefully. Read the example below before beginning, and if you have any questions please ask about them.

NAME:_____ **DOB:**_____

ADDRESS: _____

_____

PHONE: _____

PROVIDER:_____ ☑ **INITIAL**

EXAMPLE **HOW MUCH WERE YOU DISTRESSED BY:**	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Headaches	0	1	2	3	4

DATE: _____ SEX: _____

HOW MUCH WERE YOU DISTRESSED BY:		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Headaches	1.	0	1	2	3	4
2. Nervousness or shakiness inside	2.	0	1	2	3	4
3. Repeated unpleasant thoughts that won't leave your mind	3.	0	1	2	3	4
4. Faintness or dizziness	4.	0	1	2	3	4
5. Loss of sexual interest or pleasure	5.	0	1	2	3	4
6. Feeling Critical of others	6.	0	1	2	3	4
7. The idea that someone else can control your thoughts	7.	0	1	2	3	4
8. Feeling others are to blame for most of your troubles	8.	0	1	2	3	4
9. Trouble remembering things	9.	0	1	2	3	4
10. Worried about sloppiness or carelessness	10.	0	1	2	3	4
11. Feeling easily annoyed or irritated	11.	0	1	2	3	4
12. Pains in heart or chest	12.	0	1	2	3	4
13. Feeling afraid in open spaces or on the streets	13.	0	1	2	3	4
14. Feeling low in energy or slowed down	14.	0	1	2	3	4
15. Thoughts of ending your life	15.	0	1	2	3	4
16. Hearing voices that other people do not hear	16.	0	1	2	3	4
17. Trembling	17.	0	1	2	3	4
18. Feeling that most people cannot be trusted	18.	0	1	2	3	4
19. Poor appetite	19.	0	1	2	3	4
20. Crying easily	20.	0	1	2	3	4
21. Feeling shy or uneasy with the opposite sex	21.	0	1	2	3	4
22. Feelings of being trapped or caught	22.	0	1	2	3	4
23. Suddenly scared for no reason	23.	0	1	2	3	4
24. Temper outbursts that you could not control	24.	0	1	2	3	4
25. Feeling afraid to go out of your house alone	25.	0	1	2	3	4
26. Blaming yourself for things	26.	0	1	2	3	4
27. Pains in lower back	27.	0	1	2	3	4
28. Feeling blocked in getting things done	28.	0	1	2	3	4
29. Feeling lonely	29.	0	1	2	3	4
30. Feeling blue	30.	0	1	2	3	4
31. Worrying too much about things	31.	0	1	2	3	4
32. Feeling no interest in things	32.	0	1	2	3	4
33. Feeling fearful	33.	0	1	2	3	4
34. Your feelings being easily hurt	34.	0	1	2	3	4
35. Other people being aware of your private thoughts	35.	0	1	2	3	4
36. Feeling others do not understand you or are unsympathetic	36.	0	1	2	3	4

PATIENT NAME:_____ DOB:_____ DATE OF SERVICE:_____

SCL-90-R®

SIDE 2

HOW MUCH WERE YOU DISTRESSED BY:		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
37. Feeling that people are unfriendly or dislike you	37.	0	1	2	3	4
38. Having to do things very slowly to insure correctness	38.	0	1	2	3	4
39. Heart pounding or racing	39.	0	1	2	3	4
40. Nausea or upset stomach	40.	0	1	2	3	4
41. Feeling inferior to others	41.	0	1	2	3	4
42. Soreness of your muscles	42.	0	1	2	3	4
43. Feeling that you are watched or talked about by others	43.	0	1	2	3	4
44. Trouble falling asleep	44.	0	1	2	3	4
45. Having to check and double-check what you do	45.	0	1	2	3	4
46. Difficulty making decisions	46.	0	1	2	3	4
47. Feeling afraid to travel on buses, subways, or trains	47.	0	1	2	3	4
48. Trouble getting your breath	48.	0	1	2	3	4
49. Hot or cold spells	49.	0	1	2	3	4
50. Having to avoid certain things, places, or activities because they frighten you	50.	0	1	2	3	4
51. Your mind going blank	51.	0	1	2	3	4
52. Numbness or tingling in parts of your body	52.	0	1	2	3	4
53. A lump in your throat	53.	0	1	2	3	4
54. Feeling hopeless about the future	54.	0	1	2	3	4
55. Trouble concentrating	55.	0	1	2	3	4
56. Feeling weak in parts of your body	56.	0	1	2	3	4
57. Feeling tense or keyed up	57.	0	1	2	3	4
58. Heavy feelings in your arms or legs	58.	0	1	2	3	4
59. Thoughts of death or dying	59.	0	1	2	3	4
60. Overeating	60.	0	1	2	3	4
61. Feeling uneasy when people are watching or talking about you	61.	0	1	2	3	4
62. Having thoughts that are not your own	62.	0	1	2	3	4
63. Having urges to beat, injure, or harm someone	63.	0	1	2	3	4
64. Awakening in the early morning	64.	0	1	2	3	4
65. Having to repeat the same actions such as touching, counting or washing	65.	0	1	2	3	4
66. Sleep that is restless or disturbed	66.	0	1	2	3	4
67. Having urges to break or smash things	67.	0	1	2	3	4
68. Having ideas or beliefs that others do not share	68.	0	1	2	3	4
69. Feeling very self-conscious with others	69.	0	1	2	3	4
70. Feeling uneasy in crowds, such as shopping or at a movie	70.	0	1	2	3	4
71. Feeling everything is an effort	71.	0	1	2	3	4
72. Spells of terror or panic	72.	0	1	2	3	4
73. Feeling uncomfortable about eating or drinking in public	73.	0	1	2	3	4
74. Getting into frequent arguments	74.	0	1	2	3	4
75. Feeling nervous when you are left alone	75.	0	1	2	3	4
76. Others not giving you proper credit for your achievements	76.	0	1	2	3	4
77. Feeling lonely even when you are with people	77.	0	1	2	3	4
78. Feeling so restless you couldn't sit still	78.	0	1	2	3	4
79. Feelings of worthlessness	79.	0	1	2	3	4
80. The feeling that something bad is going to happen to you	80.	0	1	2	3	4
81. Shouting or throwing things	81.	0	1	2	3	4
82. Feeling afraid you will faint in public	82.	0	1	2	3	4
83. Feeling that people will take advantage of you if you let them	83.	0	1	2	3	4
84. Having thoughts about sex that bother you a lot	84.	0	1	2	3	4
85. The idea that you should be punished for your sins	85.	0	1	2	3	4
86. Thoughts and images of a frightening nature	86.	0	1	2	3	4
87. The idea that something serious is wrong with your body	87.	0	1	2	3	4
88. Never feeling close to another person	88.	0	1	2	3	4
89. Feelings of guilt	89.	0	1	2	3	4
90. The idea that something is wrong with your mind	90.	0	1	2	3	4

PATIENT NAME:_____ DOB:_____ DATE OF SERVICE:_____

SOAPP[SM]

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never	1 = Seldom	2 = Sometimes	3 = Often	4 = 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 had a problem with alcohol or drugs?	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

PATIENT NAME:_____ DOB:_____ DATE OF SERVICE:_____

SOAPP[SM] (continued)

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

15.	How often do you feel that your pain is "out of control?"	0	1	2	3	4
16.	How often do you do things that you later regret?	0	1	2	3	4
17.	How often has your family been supportive and encouraging?	0	1	2	3	4
18.	How often have others told you that you have a bad temper?	0	1	2	3	4
19.	Compared with other people, how often have you been in a car accident?	0	1	2	3	4
20.	How often have you felt a need for higher doses of medication to treat your pain?	0	1	2	3	4
21.	How often do you take more medication than you are supposed to?	0	1	2	3	4
22.	How often have you had a problem getting along with the doctors who prescribed your medicines?	0	1	2	3	4
23.	How often have you been seen by a psychiatrist or a mental health counselor?	0	1	2	3	4
24.	How often has more than one doctor prescribed pain medication for you at the same time?	0	1	2	3	4

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

PATIENT NAME:_____ DOB:_____ DATE OF SERVICE:_____

Hartford Hospital
A Hartford HealthCare Partner

Pain Treatment Center

CONTROLLED SUBSTANCE AGREEMENT AND INFORMED CONSENT FORM

<u>IMPORTANT</u>: This agreement is to be read and signed in the event your physician prescribes any controlled substances during your course of treatment at the Hartford Hospital Pain Treatment Center.

The following agreement relates to my use of controlled substances including but not limited to "narcotics/opioids," to treat chronic pain. I will be provided with prescriptions only if I understand and agree to the following:

1. I understand that, depending on the drug and dose, I can become physically dependent on the medication and can develop withdrawal symptoms if the medication is stopped suddenly or the dose reduced rapidly. Although the risk is small there is a chance of developing an addiction to controlled substances if I am placed on them to control my pain.

2. Controlled substances can cause sedation, confusion, or other changes in mental state and thinking abilities. I understand that the decision to drive while I am taking controlled substances is my own decision, and I agree not to be involved in any activity that may be dangerous to me or someone else, such as driving or operating any dangerous equipment, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself if I am in any way sedated, feel drowsy, or am not thinking clearly.

3. I will not use any illegal controlled substances including, but not limited to marijuana and cocaine. I will not drive while intoxicated with alcohol.

4. The Hartford Hospital Pain Treatment Center ("HHPTC") policy regarding the dispensing of controlled substances requires that I be seen regularly and I agree to make and keep my appointments. I will advise my doctor of all other medicines and treatments that I am receiving.

5. If the medication requires adjustment, an appointment must be made to see the doctor. No adjustments will be made over the telephone. My careful planning is required. I understand that medication refills and adjustments are done during office appointments except under very unusual circumstances. I must stay with the prescribed dosing so that I do not run out of medication early. I understand that the HHPTC policy is not to prescribe early. I agree that I will use my medication exactly as prescribed and that if I run out early, I may go without medication until the next prescription is due, possibly resulting in withdrawal symptoms.

6. I understand that the prescriptions are my responsibility once they are placed in my hand and that if anything happens to my prescription (lost, stolen, or accidentally destroyed), I may not receive a replacement from my physician. HHPTC expects me to file a police report if my medication is stolen. I will be prepared to bring in a copy at my next office visit.

7. My physician will prescribe whatever medication he/she is comfortable with and thinks is best; he/she is not under any obligation to prescribe any specific medication.

8. I am aware of the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed included: injections, therapy, and surgery (if indicated).

9. I agree to come to the HHPTC with my medication on the same day that I am called and submit to a pill count, to determine proper usage of medication. The call to come to the HHPTC can be made either randomly, or if a concern arises. I may also be required to bring my unused medication routinely to each office visit. **In addition , at any point during my care at HHPTC, I agree to undergo a urine or blood screen to detect illegal substances or confirm proper use of prescribed medicine. This screening can be done randomly, without notice to me, the patient.** If I do not have insurance or my insurance denies testing, I will be responsible for the cost of the test.

10. I give permission to the HHPTC staff to call any pharmacy or another health care provider at any time, without my being informed, to discuss my past or present use of controlled or illegal substances.

11. I will not use my pain medication in higher than prescribed amounts for new problems that arise (toothache, surgery, etc.) unless authorized to do so. I will inform my other doctor(s) of my use of medication for chronic pain, and I will inform the HHPTC staff if another physician prescribes controlled substances for the acute problem. My doctor at HHPTC is my primary doctor with regard to my pain medications. If there is a medical emergency (e.g., broken leg, surgery requiring post-op pain medication, dental procedures, etc.), another doctor may prescribe pain medication to me, but I will advise the prescribing doctor of my care at HHPTC, authorize the doctor to disclose information to HHPTC, and I will also notify my doctor at HHPTC of the medication and dosage.

12. (Females only) Because of the risks of certain medications to unborn children, I will inform all physicians, obstetrician/gynecologist and HHPTC, immediately if I become pregnant or decide to try to become pregnant. 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 the use of opioids is not generally associated with 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.

13. (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.

14. My physician can wean me off of controlled substances at any time if he/she feels that it is in my best interest. The weaning process can result in withdrawal symptoms. If I am weaned off, the HHPTC staff may inform my other health care providers as to the reasons for the weaning.

15. Abstinence Syndrome (Withdrawal Syndrome): Stopping my opioid, antiseizure or antidepressant medication abruptly may result in withdrawal symptoms (flu-like symptoms, GI distress, diarrhea, sweating, heart palpitations, and rarely seizures or death). I should wean from my medications rather than stopping them abruptly. If I find myself without medication, I will use the emergency line to notify my doctor.

16. I understand that in general I may be weaned off of my medication or my drug therapy may be terminated at the discretion of my physician if any of the following occur:

    a) It is the opinion of my physician that controlled substances are not very effective for my pain and/or my functional activity is not improved.

    b) I misuse the medication.

    c) I develop rapid tolerance or loss of effect from this treatment.

    d) I develop side effects that are significant and detrimental to me.

    e) I obtain controlled substances from other sources other than my physician without informing him or her.

    f) Pill counts or test results indicate the improper use of the prescribed medication or the use of other drugs, and/or I fail to submit to such counts/tests on the day that I am called.

    g) I am arrested and/or convicted for a controlled or illicit drug violation, including drunk driving.

    h) Any violation of this agreement.

17. I further understand that my drug therapy will be terminated or detoxification in a controlled environment will be required if I give away, sell, distribute and/or transport with the intent to sell or dispense my medication.

18. I choose to use _____ Pharmacy, located at _____, for all of my pain medication prescriptions. I will not fill partial prescriptions if my pharmacy does not stock the full quantity of medication. If I change my pharmacy for any reason, I agree to notify my pain physician.

I have read the above Agreement and understand the Agreement, have had all my questions concerning this Agreement answered to my satisfaction, and I agree to abide by the terms of this Agreement if I am placed on controlled substances (including, but not limited to narcotic analgesics). I have received a copy of the Agreement. By signing this form voluntarily, I give my consent for the treatment of my pain with narcotic/opioid pain medicines.

_____ _____
Patient Date

_____ _____
Physician Date

Hartford Hospital
A Hartford HealthCare Partner
Pain Treatment Center

Prescription Notification Policy

As part of our computerized prescribing system, Hartford Hospital Pain Treatment Center receives daily updates from pharmacies on all prescriptions written for our patients by any provider. This process has been put in place to improve the quality and coordination of your care. It helps us identify drug interactions and prevent duplication of services when you are seen in other settings, such as emergency rooms and out-of-state facilities.

Please inform our staff if you wish to "opt out" of automated prescription notification.

You don't need to do anything if you are comfortable with pharmacies letting our Pain Center know what medications you are taking.

PATIENT NAME:_____ DOB:_____ DATE OF SERVICE:_____

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OFFICE RULES & POLICIES

CO-PAYMENTS
Co-payments are due at the time of your visit.

Insurance regulations REQUIRE us to collect co-payment.

Under no circumstance are we able to waive co-payment. If you do not have your co-pay for your visit, your appointment may be re-scheduled.

BOUNCED CHECK
A $25.00 CHARGE WILL BE ASSESSED FOR RETURNED CHECKS.

NO SHOW OR CANCELLATIONS
A $100 (New Consult) or $50 (Follow-up, Procedure) charge will be assessed if you fail to keep your appointment and do not notify the office. Failure to provide 24-hour advance notification for a cancellation or rescheduled appointment will result in a fee charged.

Established Patients: Patient may be discharged from the practice after THREE “NO SHOWS” or CANCELLATIONS occurring within 24 hours.

PHONE CALLS
Patients are limited to a maximum of two phone calls per day. Callbacks from the Hartford Hospital Pain Treatment Center Staff will be returned within 24 hours depending on the urgency of the call.

LANGUAGE
Rude or disrespectful language will not be tolerated.

AGREEMENT
In order to become and continue as a patient of the Hartford Hospital Pain Treatment Center, I understand the rules and policies set by the Practice and agree to abide by set office rules and policies.

Thank you for your consideration.

_____	_____	_____
Printed Name	Signature	Date

PLEASE SIGN AND BRING THIS WITH YOU TO YOUR FIRST VISIT.

PATIENT NAME:_____ DOB:_____ DATE OF SERVICE:_____

Hartford Hospital

If you use any assistive device such as a cane or a walker, please bring it with you when you come in for your

Hartford Hospital
A Hartford HealthCare Partner
Pain Treatment Center
"In the heart of Blue Back Square"

65 Memorial Road
Suite 435
West Hartford, CT 06107

Phone: 860-696-2840
Fax: 860-696-2845

PATIENT NAME:_____ DOB:_____ DATE OF SERVICE:_____