PATIENT'S INFORMATION

Date: _____

Patient Name: _____
Last Name *Suffix* *First Name* *MI*

Permanent Mailing Address: _____

Physical Address: _____
If different than mailing

Home Phone: _____ Cell Phone: _____ DOB: _____

Social Security #: _____ E-Mail: _____ Marital Status _____

Race: _____ Ethnicity: ☐ Hispanic ☐ Not Hispanic Language: _____

Sex: ☐ M ☐ F Gender Identity: ☐ Female-to-Male/ Transgender Male ☐ Male-to-Female/ Transgender Female ☐ Non-Binary/ Genderqueer ☐ Others

Employer Name: _____ Employer Phone: _____

Employer Address: _____

Preferred Pharmacy: _____ Pharmacy Location: _____

Emergency Contact: _____ Relationship: _____ Phone: _____
Leave blank if none

Primary Care Physician:_____ Referring Physician/Facility: _____

PCP City:_____ Referring City: _____

PCP Phone: _____ Referring Phone: _____

INSURANCE INFORMATION

Is this visit due to one of the following? ☐ Worker's Comp ☐ Liability ☐ Motor Vehicle Date of Injury: _____

Primary Insurance Co.: _____ Relationship to Subscriber: _____
If patient is not the subscriber complete the following.

Subscriber's Full Name: _____ SSN: _____

Subscriber's Address: _____

Subscriber's Sex: ☐ M ☐ F DOB: _____ Employer: _____

Subscriber's Employer Address & Phone: _____

Secondary Insurance Co.: _____ Relationship to Subscriber: _____
If patient is not the subscriber complete the following.

Subscriber's Full Name: _____ SSN: _____

Subscriber's Address: _____

Subscriber's Sex: ☐ M ☐ F DOB: _____ Employer: _____

Subscriber's Employer Address & Phone: _____

PARENT/GUARDIAN INFORMATION

If patient is a minor.

Father's Name: _____

Last Name *Suffix* *First Name* *MI*

Father's Mailing Address: _____

Father's Home Phone: _____ Cell Phone: _____

Father's DOB: _____ Father's SS#: _____

Father's Employer: _____

Employer Address: _____ Phone: _____

Mother's Name: _____

Last Name *Suffix* *First Name* *MI*

Mother's Mailing Address: _____

Mother's Home Phone: _____ Cell Phone: _____

Mother's DOB: _____ Mother's SS#: _____

Mother's Employer: _____

Employer Address: _____ Phone: _____

Pain Care Center
A UNITY HEALTHCARE PARTNER

1345 Unity Place, Suite 355 | Lafayette, IN 47905
Ph: 765.807.7988 | Fax: 765.807.7989

I have received and read the Patient Information Pamphlet that was provided with my new patient information and packet. I acknowledge and understand the information stated in the Patient Information Pamphlet.

Patient Signature: _____

Patient Printed Name:_____

Date of Birth: _____

Date Signed: _____

Thank you for your cooperation,
The Pain Care Center

UNITY HEALTHCARE, LLC
DISCLOSURE AND RELEASE AUTHORIZATION

CONSENT TO TREAT: I request and give consent to my Unity Healthcare, LLC ("Unity") healthcare professional to provide and perform such medical/surgical care, therapy, tests, procedures, drugs, and other services and supplies as my healthcare professional, in their professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties, or guarantees as to the results or cures have been made to me or relied upon by me.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been offered a copy of the Unity Notice of Privacy Practices and understand that my protected health information ("PHI") may be used by Unity as described in such Notice.

OWNERSHIP DISCLOSURE: I acknowledge that Unity and indirectly, Unity's physicians, have an ownership interest in Unity Surgical Center ("USC"), and InnerVision Advanced Medical Imaging Center ("InnerVision"). I understand that I am free to determine which facility to utilize for health care services, and neither Unity nor my physician shall discriminate in the care provided to me should I desire to use a facility other than USC and InnerVision.

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize Unity and my healthcare professional to release information from my medical records to my insurance carrier(s), governmental agency, or my employer in the case of work-related injuries or services for the purpose of processing claims for medical/workers compensation benefits and state on such claims that my signature is on file. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my healthcare professional on my behalf.

FINANCIAL AGREEMENT: I understand and agree to all the following:

a. All accounts are the full responsibility of the patient and/or the patient's responsible party guarantor.
b. No conditional payments accepted, and payments with attempted conditions will be applied to any amounts owed.
c. Unity will assist me in obtaining insurance benefits when those benefits are assigned to my/the patient's healthcare professional. I have provided complete information regarding my/the patient's primary and secondary health insurance, as applicable.
d. I am responsible for making sure insurance payments are processed and paid promptly to my healthcare professional. In addition, I must provide my prompt payment of any amount owed to Unity that is deemed "Patient Responsibility" under my insurance contract (for those payors with which Unity is a participating healthcare professional or "in-network"). Otherwise, it is my responsibility if my insurance does not cover such services or Unity is a non-participating healthcare professional or "out-of-network".
e. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. I agree that reasonable attorney fees shall be interpreted as 40% of any balance due at the time the account is sent to an attorney or collection agency for collection, or $300.00, whichever is greater.
f. Tippecanoe County, Indiana, shall be the preferred venue for any legal action related to this financial agreement, and I agree to waive my right to a trial by jury.
g. This financial agreement is being entered into individually and as an authorized agent for my spouse, if any. This financial agreement may be assigned by Unity to an attorney who purchases Unity's delinquent accounts, and the terms of this agreement shall remain binding.
h. A fee may be charged for any appointments not canceled at least twenty-four (24) hours in advance or missed for any other reason. These are generally not payable by insurance. I am responsible for these fees.
i. Unity Immediate Care (UICC) is not a participating provider with or under the Indiana Medicaid program. As a result, any medical or related services provided by the UICC will not be covered or paid by the Medicaid program.

OTHER PROVIDERS: I understand that in addition to the attending physician, other healthcare professionals, such as radiologists and pathologists, and other providers, such as laboratories and other medical professionals, may be involved in my care and may separately bill me for their services.

INDIANA LAW AND JURISDICTION: I understand that I am being provided treatment in the State of Indiana, and I agree that if I should have any claim with regard to my care or treatment, such will be decided in accordance with Indiana law and such action will be brought and decided in a Court in the State of Indiana.

NOTICE OF NONDISCRIMINATION: Unity complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, sex, or gender identity.

MEDICARE CERTIFICATION: (IF APPLICABLE) I certify that the information given by me, or by Unity on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating healthcare professional to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of the processing of claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made directly to Unity or my treating physician on my behalf.

Please read and initial each of the following statements before signing this form. By initialing you indicate that you have read, understand and agree to each.

_____ AUTOMATED CONTACT: I authorize Unity and its affiliates and agents to use automated messages to contact me at the e-mail and phone numbers I have provided. These messages will provide information to me, such as *appointment information*, *closure messages*, *health services*, or *account information*. These may come in the form of a text message, automated call (whether a cell phone or a landline), or e-mail and will be left at the number or e-mail provided to any Unity healthcare professional. If I receive treatment from multiple Unity healthcare professionals, I may receive multiple messages referencing appointments/services from each office. I understand that I have the right to opt-out of any of these contact methods at any time, either by an opt-out within the message or by speaking to a Unity representative. Any opt-out request to a Unity healthcare professional will remove that contact method from ALL Unity Healthcare, LLC healthcare professionals. I understand I can later request to opt back into automated messages by speaking to a Unity representative.

_____ PHOTO CONSENT: My healthcare professional may request photos. I consent to have my photographs taken by my healthcare professional or designated associate if required and permit the use of photographs for identification, medical records, education, and lectures.

My signature below constitutes my acknowledgment and agreement that I have read and understand the consent, notices, disclosure, and other information provided.

Patient/Parent/Guardian

Print Patient Name: _____ Signature: _____ Date: _____

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Pharmacy Sheet

Patient Date of Birth: _____

Pharmacy used (Street/City Included): _____

It is the patients responsibility to use ONLY ONE pharmacy. Multiple pharmacy usage will not be accepted, it is also a violation of the opiate agreement you have with the Pain Care Center. If you choose to switch pharmacies you need to call the Lafayette Office at (765) 807.7988 and explain the reasons why you are choosing to switch and which pharmacy you are switching to. Patients are not allowed to switch pharmacies multiple times.

I have read and understood the above statement about usage of only one pharmacy.

_____ _____

Patient Name (Signed) Date

_____

Patient Name (Printed)

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Opiate Medication Information

The purpose of this information sheet is to notify you, the patient, of possible side effects, addiction and overdose of opiate medications that you may be prescribed by this office. PLEASE read this to its entirety and any questions you may have can be presented to a member of the staff.

It is important to remember that opiates only suppress the pain, they do NOT fix the problem that is causing the pain. Every medication comes with possible side effects, the following are just some of the common side effects that you may encounter while taking opiate medication:

- Emotional and physical dependence
- Constipation (we suggest taking a daily stool softener while on opiates)
- Nausea with or without vomiting • Drowsiness • Dizziness • Weakness • Dry mouth
- Confusion • Difficulty with urination • Itching • Respiratory Depression (slowed rate of breathing)
- Reduced sexual function
- Decreased ability to perform activities such as driving and using machinery (we ask that you not drive or operate machinery until you know how your medication will affect you.)

Physical and/or mental dependence can occur while taking opiate medications, which is rare (occurring in approximately 1 in 10,000 patients without a history of substance abuse). Becoming addicted to pain medication is a disease and you should seek advice and help if you feel this is occurring. It is important to be aware that taking chronic, long term use of opiate pain killers can possibly cause a decrease in the ability to tolerate pain and increase the sensitivity to pain. Remember, you are to ONLY take the medication as it is prescribed by your physician.

Opiate drugs taken with alcohol or street drugs, or in great doses than prescribed, can cause increased side effects leading to dangerous situations such as coma, organ damage, or even death.

Only take medications that are prescribed by your physician and take them as prescribed. Possible unintentional or intentional overdose can occur if not taking medications as prescribed. If you are experiencing a possible overdose seek the help of 911 or go to your closest emergency room.

I have read the above fully and understand it to all of its intent. I hold full responsibility to use medications as prescribed and only as prescribed by my physician. I understand possible side effects, dependency and overdose of opiate medications that I may be prescribed.

X_____

Staff Signature: _____

Patient received a copy of this on: _____

Printed Name & Date of birth: _____

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Patient / Physician Treatment Agreement

Patient Printed Name: _____ **DOB:** _____

Patient needs to initial next to each statement stating that you have read and understood the statement. Sign the agreement at the end of the statements.

Disclaimer: This document is a record of agreement between you and your medical provider at the Pain Care Center concerning the use of pain medications. The purpose of this agreement is to explain the rules as well as to comply with state and federal laws/regulations regarding controlled pain medication(s). **MEDICATIONS ARE THE RESPONSIBILITY OF THE PATIENT.**

___ I will **NOT** use any illegal substances nor will I take medications that are not prescribed to me. I will **NOT** share, sell, or trade my medications regardless of the situation. If I require a change in medication(s), I am required to bring any/all of the previous medication(s) back to the Pain Care Center for count prior to receiving a new prescription. I will **NOT** dispose of medication on my own. Medication(s) will not be refilled early or replaced/changed until the due date if disposed of by the patient. If I fail to comply, I may be discharged from the practice.

___ I agree to submit to a drug screen at the request of the Pain Care Center. I understand that refusal of this screen will result in automatic termination of medication(s) and care from the Pain Care Center.

___ I understand and agree that my medication(s) will **NOT** be refilled earlier than scheduled and I agree not to ask this of my physician. This includes **NOT** self increasing my pain medication(s) without the prior approval of the physician. In the event that my refill date falls on a day the office is not open, I will be able to pick up my prescription on the business date prior but will **NOT** start taking the medication until the date it is due.

___ I agree to use only Dr.Bigler / Dr. Ramos to obtain any/all pain medication(s). if I do not do so, then I may be subject to non medication treatment or immediate dismissal of the Pain Care Center.

___ I agree to use only **ONE** pharmacy during the course of treatment. If wishing to change pharmacies, inform the medical staff of the change in advance. This agreement authorizes tour physician to provide a copy of the agreement to the designated pharmacy.

___ I will safeguard my pain medication(s) from LOSS or THEFT. I understand that lost, washed, dropped, or stolen medication(s) may not be refilled until the date due and **I agree not to ask this of my physician**.

___ I understand that a ONE TIME exception may be made in the event that I provide a police report documenting the loss or theft of my medication(s). I will report the loss or theft to the Pain Care Center immediately and understand that repeat loss or theft may result in discontinuation of medication(s) or care from the Pain Care Center. This one time exception will not be prior authorized by the Pain Care Center with my insurance company if the insurance company will not cover the cost of medication(s).

___ I understand that my medication(s) will not be changed due to loss or theft.

Patient / Physician Treatment Agreement Continued:

___ I understand that all of the medications prescrived to me should remain in a **LOCKED** safe at all times and the only medication(s) out of the locked safe are the specific amount of medications to be used for that particular day. I understand that if going out of town I will only carry the amount of medication(s) needed for the time gone and will be carried in the original bottle.

___ I agree to come in on the day the Pain Care Center calls for a random medication(s) count so all of the medication(s) can be counted and documented in the chart by two medical personnel; the medication(s) MUST be in the original bottle(s). I understand that I must provide the Pain Care Center with a valid phone number and address.

___ I have read and understand the above information. I have been given a chance to have all questions/concerns answered and addressed adequately. I understand that a copy of this agreement is available to me at any time, upon my request.

___ I understand that failure to follow the rules may be unsafe for my health and may result in the termination of medication(s) and could result in management of my condition with other modalities. It may also result in my discharge from the Pain Care Center.

This agreement is entered into on this date: _____

X_____
Patient Signature

_____
Witness

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Medication Usage Sheet

Patient Printed Name: _____ **DOB:** _____

BRING MEDICATIONS IN THEIR ORIGINAL BOTTLES TO THE APPOINTMENT
(Including vitamins and over the counter medications)

Name of Medication	Strength	Directions for Use: AS STATED ON BOTTLE	Prescribed By

Allergies: List allergy and reaction below

1. _____ 3. _____

2. _____ 4. _____

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CONFIDENTIAL

Date: _____ **Age:**_____ **DOB:**_____ □ **M** □ **F**

Patients Name (Please Print) _____
Last **First** **Middle Initial**

Referring Physician: _____ Family Physician:_____

Height:_____ Current Weight: _____ Weight ONE year ago:_____

What pain problem brings you here today? _____

Surgery: Please list **any** previous surgeries that you've had. **Include** type of surgery and the year.

1._____ 4. _____

2._____ 5. _____

3._____ 6. _____

Have you ever had problems with Anesthesia? □ No □ Yes, if so what? □ Prolonged Paralysis □ Problems waking up □ Malignant Hypertension

Major Illnesses: Please list **major** hospitalizations for medical problems, **include** diagnosis and year.

1._____ 4. _____

2._____ 5. _____

3._____ 6. _____

Allergies: Please list any allergies **and** type of reaction (trouble breathing, rash, hypertension, swelling, etc.)

1._____ 4. _____

2._____ 5. _____

3._____ 6. _____

Do you have a latex allergy? □ No □ Yes

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HISTORY OF YOUR PAIN

Patient Printed Name: _____ **DOB:** _____

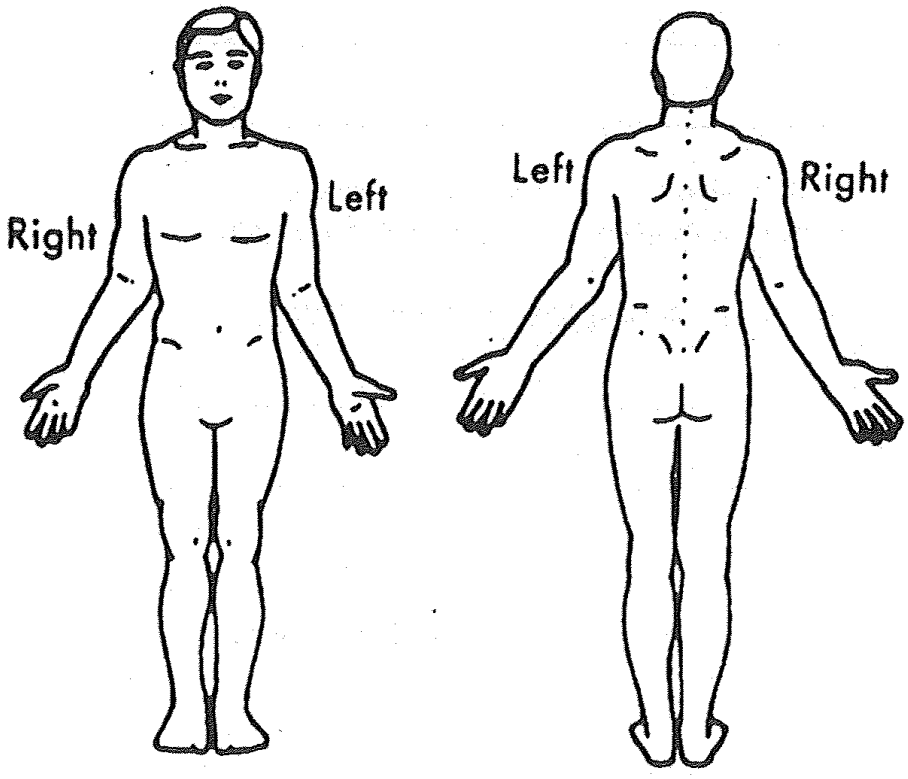
Please write the number of pain that most appropriately reflects your pain on the scale of 0 to 10
0 = **NO** pain 10 = incapacitating / can **NOT** move or get out of bed

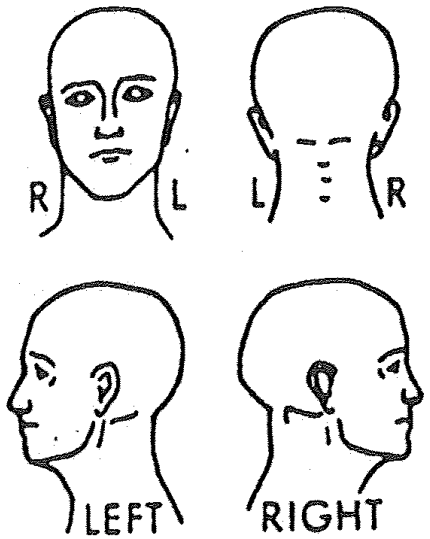
At its worst in the last week_____ At its least in the last week_____ Average Pain Scale _____

On the drawing, **PLEASE** shade the areas where you feel pain.

Then, **NEXT** to or on the shaded area:

Put an **"X"** if pain is **EXTERNAL**, but an "I" if the pain is **INTERNAL**, or an **"XI"** if the pain is **BOTH** external and internal.





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MEDICAL REVIEW

Have you had or do you have any of the following? **PLEASE check problem if check YES**

General Health □ No □ Yes □ Recent Fever □ Unexplained Weight Loss □ Fatigue □ Frequent Illness

Eye Problems □ No □ Yes □ Glasses □ Contacts □ Blindness □ Cataracts □ Glaucoma □ Prosthetic Eye

Ear/Nose/Throat □ No □ Yes □ Hearing Loss □ Deafness □ Hearing Aids □ Frequent Sinus Infections
□ Swallowing Problems

Cardiovascular □ No □ Yes □ Angina □ Irregular Heartbeat □ Heart Attack □ Heart Murmur □ Heart Failure
□ Rheumatic Fever □ High Blood Pressure □ Low Blood Pressure □ Heart Surgery
□ Blood Vessel Blockage □ Pacemaker □ Valve Replacement □ Implantable Defib Device

Respiratory □ No □ Yes □ Emphysema □ COPD □ Asthma □ Sleep Apnea □ Short of Breath □ TB
Date of last chest X-Ray: _____ Other: _____

Gastro-Intestinal □ No □ Yes □ Ulcers □ Hemorrhoids □ Ostomy □ Hiatal Hernia □ Cirrhosis □ Gallstones
□ Yellow Jaundice Other: _____

Urinary □ No □ Yes □ Renal Failure □ Dialysis □ Prostate Enlargement □ UTI □ Kidney Stones
□ Prostate Infection Other: _____

Musculoskeletal □ No □ Yes □ Broken Bones / Joint Replacement (If so, what?) _____
□ Limited Back Movement □ Limited Neck Movement □ Decreased Muscle Strength
□ Decreased Muscle Size Other: _____
Have you had a: Neck Injury □ No □ Yes Back Injury □ No □ Yes

Integument (Skin) □ No □ Yes □ Changing Moles □ Skin Lesions □ Breast Lump Other:_____

Neurological □ No □ Yes □ Epilepsy □ Stroke □ TIA □ Migraine □ Speech Difficulty □ Mute □ Parkinson's
□ Alzheimer's □ Multiple Sclerosis □ Head Injury Other: _____

Psychiatric □ No □ Yes □ Nervous Breakdown □ Depression □ Schizophrenia Maniac Depression Bipolar
□ Anxiety Other: _____

Endocrine □ No □ Yes □ Hypothyroid □ Hyperthyroid □ Menstrual Irregularity Other:_____
□ Diabetes

Hematological □ No □ Yes □ Swollen Lymph Nodes □ Anemia □ Blood Loss □ Transfusion □ Leukemia

Transmissible Diseases □ No □ Yes □ History of TB □ Recent TB Exposure □ Positive TB Test □ Hepatitis A
□ Hepatitis B □ Hepatitis C □ HIV Positive □ AIDS Other: _____

Cancer □ No □ Yes If so, what type: _____ Treatment: _____

Are there any other medical problems we should be aware of? □ No □ Yes, please explain _____

Family History: Please circle **ANY** of the following if they are present in ANY of your family members (blood relatives)
Adopted? □ No □ Yes

□ Cancer □ Diabetes □ Epilepsy □ Heart Trouble □ High Blood Pressure □ Stroke □ Mental Illness
□ Muscular Disease □ Tuberculosis □ Connective Tissue Disease

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Patient Name: _____ **Patient Date of Birth:** _____

Tobacco Use
Do you currently smoke? □ No □ Yes Did you ever smoke? □ No □ Yes If so, when did you quit? _____
How many years have/did you smoke? _____ How many packs a day? _____
Do you use chewing tobacco? □ No □ Yes

Alcohol / Illegal Substance Use
Do you, or did you ever use alcohol regularly? □ Never □ Not regularly □ Socially □ Yes If yes, how much? _____
Have you ever been treated for alcoholism? □ No □ Yes If yes, when?
Have you ever been treated for drug addiction? □ No □ Yes If yes, when?
Have you ever used illegal drugs? □ No □ Yes If yes, when and what?

Females: Are you pregnant? □ No □ Yes Could you become pregnant? □ No □ Yes
Birth Control Method: _____

Males: Do you have erection problems? □ No □ Yes Do you have problems with impotency? □ No □ Yes

Social History
I currently live: □ in a house □ in an apartment □ in a mobile home □ in a retirement center
□ Other (please specify) _____

I currently live: □ on the first floor □ on another level □ in a place where I climb stairs daily

I currently: □ live alone □ live with my family □ live with a significant other □ have home care or visiting nurse

I currently have an "at home" caregiver. □ No □ Yes If yes, name of caregiver _____

Caregivers Phone # _____Caregiver's relationship to you? _____

Is your primary caregiver in good health? □ No □ Yes Caregiver's level of education? _____

Work Activities
Current Employer: _____ Job Title: _____

Have you had to alter your job as a result of the problem that brought you here today? □ No □ Yes

If yes, please explain _____

What is your current work status? □ Working Full Time □ Working Part Time □ Student □ Disabled □ Unemployed □ Retired

How long have you been off work?_____

Do you have a work disability? □ No □ Yes (if so, please explain) _____

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PAIN ASSESSMENT

Patient Name: _____ **Patient Date of Birth:** _____

Location and description of pain: _____

Please describe briefly how your pain began: _____

_____

What relieves your pain? _____

What worsens your pain? _____

Please check the number that reflects your CURRENT percentage of pain
□ 0% □ 20% □ 40% □ 60% □ 80% □ 90% or plus _____ (Incapacitating/can NOT move or get out of bed)

Please check the number that reflects your CURRENT percentage of pain WHILE performing your NORMAL activities
□ 0% □ 20% □ 40% □ 60% □ 80% □ 90% or plus _____ (Incapacitating/can NOT move or get out of bed)

Please check the number that reflects your CURRENT percentage of pain WHILE performing your job
□ 0% □ 20% □ 40% □ 60% □ 80% □ 90% or plus _____ (Incapacitating/can NOT move or get out of bed)

	YES/NO	WHEN	RATE OF RELIEF OBTAINED? (GOOD, FAIR, POOR)	NUMBER OF VISITS	LENGTH OF TREATMENT
Physical Therapy					
Brace					
Nerve Injections					
Chiropractic					
Traction					
TENS Unit					
Other					

This information was provided by _____
Signature of patient or person filling out packet

_____
Printed Name if other than patient Relationship Date

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MEDICATION REFILL REQUEST

PLEASE call the office refill line @ (765) 807.0340, **at least 3 business days before running out of medication.** On the date the patient's medication is fue to be filled it will be sent to the pharmact unless it is a rescription that requires a printed script, then you will need to come into the office to pick up your prescription.

- Medication is the responsibility of the PATIENT.
- Medication will not be filled the same day that it is called into request line, and weekend hours and holidays do not count towards the 3 day notice, even though medications can be requested on the refill line 24 hours a day, 7 days a week.
- It is up to the patient to pick up printed scripts from the office during normal business hours (Monday – Thursday 8:30am-5pm and Friday 8:30am – 4:30pm).

**** If you call to request after 3:30pm on Friday the prescription will not be ready until Thursday. ****

Again, this is for patient's convenience but the office doesn't count weekend hours Friday after 3:30pm until Monday 8:30am) or the holidays towards the 3 day notice.

Please, only leave refill requests on this line, not medical complaints or concerns, as they will not be able to be addressed through this line. Also, calls will not be returned from the refill line.

PRESCRIPTIONS PICKED UP AT THE OFFICE

- Please do **NOT** contact the office to inquire if your medications are ready for pick up. If you have given the proper notice and your medications are due they will be available for pick up.
- We apologize for the inconvenience but questions about prescriptions being available will not be answered.
- Medications can **NOT** be picked up prior to the date they are due.
- A **3 Business Day** request must be given prior to refilling medication. Refill line is open 24 hours a day, 7 days a week @ (765) 807.0340.
- You must have a future appointment scheduled AND your account payments must be current.
- Prescriptions are 28 days; therefore you will always be due on the SAME day of the week.

Thank you for your understanding, cooperation and allowing us to continue in the process of your care.

Request on	**Filled on**
Monday	Thursday
Tuesday	Friday
Wednesday	Monday
Thursday	Tuesday
Friday	Wednesday

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Date:_____
Patient Name:_____

Opioid Risk Tool

		Mark Each That Apply	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	□	1	3
	Illegal Drugs	□	2	3
	Prescription Drugs	□	4	4
Personal History Of Substance Abuse	Alcohol	□	1	3
	Illegal Drugs	□	2	3
	Prescription Drugs	□	4	4
Age (Mark box if 16-45)		□	1	1
History of Preadolescent Sexual Abuse		□	3	0
Psychological Disease	Attention Deficit Disorder	□	2	2
	Obsessive Compulsive Disorder	□	2	2
	Bipolar	□	2	2
	Schizophrenia	□	2	2
	Depression	□	1	1
Total		_____		

Total Score Risk Category Low Risk 0 - 3 Moderate Risk 4-7 High Risk ≥ 8

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EIGHT OPIOID SAFETY PRINCIPLES FOR PATIENTS AND CAREGIVERS

1. Never take an opioid pain medication that is not prescribed to you.
2. Never adjust your own dose.
3. Never mix with alcohol.
4. Taking sleep aids or antianxiety medications together with opioid pain medication can be dangerous.
5. Always tell your healthcare provider about all medications you are taking from any source.
6. Keep track of when you take all medications.
7. Keep your medications locked in a safe place.
8. Dispose any unused medications.

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A UNITY HEALTHCARE PARTNER

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Diagnosis's Treated

- Arthritis back pain
- Cervicogenic headaches
- Degenerated disc related pain
- Facial pain
- Fibromyalgia
- Joint pain in the shoulder, hips and knees
- Lumbar vertebral compression fracture
- Myofascial pain
- Neck pain
- Occipital neuralgia
- Pain after surgery or trauma
- Painful diabetic neuropathy
- Peripheral neuralgia
- Post laminectomy syndrome (after back surgery)
- Post herpatic neuralgia (Shingles pain)
- Radiculopathy / pinched nerves in the neck, mid back, low back causing sciatica
- Reflex sympathetic dystrophy / Complex regional pain syndrome
- Rib / Chest pain (non cardiac)
- Spinal stenosis

Pre-Procedure Instructions

- You have an upcoming procedure with your physician; in preparation for this procedure we need you to please follow the following instructions:
- No eating or drinking for 6 hours before the procedure
- You may take your regular medication with a sip of water
- Bring a driver with you. This is for any procedures that will be done with sedation or any procedure done by Dr. Ramos
- Stop taking Plavix and Pletal 7 days before procedure. The office will contact your prescribing physician for approval to stop taking Plavix or Pletal.
- Stop taking Aggrenox and Persantin 14 days before your procedure. The office will contact your prescribing physician for approval to stop taking these medications.
- Stop taking Aspirin and Vitamin E, Fish Oil, Ginko and Garlic 10 days before procedure.
- Stop taking ALL other blood thinners, including NSAIDS for 7-10 days prior to your injection. This includes Ibuprofen, Aleve, Naproxen, Advil, Motrin, Etodolac, Mobic, Daypro, Relafen, Excedrin, and Voltaren (if you need to clarify please call the office).
- Stop taking Coumadin 5 days before procedure. Arrive on time to have blood work done. The office will contact your prescribing physician for approval to stop taking Coumadin. (If being bridged with injection needs to be no later than 14 hour PRIOR to the procedure.)
- If you are diabetic and you will be sedated for this procedure:
    - Do not eat or drink
    - Do not take your insulin
    - Bring your insulin with you to the procedure

Treatments Offered

- Medication Management
- Bursa Injection
- Caudal Epidural Steroid Injections
- Cervical Epidural Steroid Injections
- Discograms
- Hardware Injections
- Ilioinguinal Nerve Block
- Intercostal Nerve Block
- Joint Injections
- Lumbar Epidural Steroid Injections
- Medical Branch Nerve Blocks
- Occipital Nerve Blocks
- Radiofrequency
- Sacroiliac Joint Injection
- Selective Nerve Block
- Stellate Ganglion Block
- Spinal Cord Stimulator
- Synvisc Knee Injection
- Transforaminal Epidural Steroid Injections
- Trigger Point Injections
- Thoracic Epidural Steroid Injection

Post-Procedure Instructions

Please contact your physician if you experience any of the following symptoms: Fever, weakness, severe pain, or any other symptoms.

Diet: Regular as tolerated

Activity: You should have someone drive you home after the procedure. You should rest today. You may resume activity tomorrow as tolerated. You should be able to return work tomorrow. Be careful to avoid strenuous activity or any activities that may cause pain or discomfort.

Special Instructions: Do not drive a motor vehicle for 24 hours after your procedure. Do not operate heavy machinery or use power tools. If you have discomfort at the injection site, place a cold pack over the injection site for fifteen minutes every two hours for the first twelve hours. The soreness usually responds will to Tylenol or Ibuprofen. **After 24 hours any muscle tightness should be treated with a heating pad or by directing water from a hot shower to the area of soreness.** You may have some return of your limb discomfort after the local anesthetic wears off which should resolve after the steroid medication starts to work. **Please do not perform vigorous activity for one week.** When you are feeling better, slowly increase your activity. We ask that you please be prepared for the office to contact you 5-10 days following your injection with the questions below.

- Percentage of relief from your procedure
- How long you experienced relief
- What activities you had difficulty with Prior to the procedure and if they have improved following the procedure
- If you are able to better do your activities of daily living
- Inform the staff of any side effects (if applicable)

Please do NOT go home and sleep following the medial branch block (MBB), transforminal episdural steroid injection (TFESI0, or a selective nerve root block (SNRB) as the office needs to know your relief within the FIRST 4 hours following the procedure.