The University of Tennessee
WEST
Cancer Center
Methodist Healthcare Family

INFORMATION SHEET FOR THE DEPARTMENT OF PAIN AND PALLIATIVE CARE

Please review the following instructions as it contains important information regarding the management of your pain. Once reviewed, our office will ask that you please sign a copy of this information sheet to confirm your receipt and to acknowledge your complete understanding.

1. On each visit to the West Cancer Center, we ask that you bring all medications, including any vitamins or herbal products that you may be taking. If a medication is not working you must return your remaining pills, patches etc. Please do not destroy them on your own.

2. In the event you see physicians other than those employed by West Cancer Center, please be certain to have these physicians contact Dr. Kaufman to discuss medical findings and that a copy of your medical records including relevant test results, be delivered to Dr. Kaufman for review. Please be certain to indicate to Dr. Kaufman, at each visit to West Cancer Center, those physicians from whom you are or intend to seek treatment. In an effort to adequately manage pain, it is necessary for us to be fully apprised of medical findings and therefore, you should also be certain all of your physicians fax to **901-322-2993** directly to Dr. Kaufman a summary of recent findings.

3. To maintain safety in prescribing controlled medications, we ask that Dr. Kaufman be your designated physician in prescribing your pain medications. If you are prescribed medications in an emergency situation by another physician you must inform us within 48 hours. Otherwise, do not take pain medication prescribed by another physician without clearing this with Dr. Kaufman. It is your responsibility to keep all of your physicians and phar-macists informed of all the medications (including over the counter medications, vitamins, etc.) that you are taking. We strongly encourage you to use one pharmacy so that they may also monitor for any possible drug interactions. You must take your medications only as prescribed. Do not increase/change your dose or take medications more frequently than ordered. Do not take any one else's medication and do not share your medications with anyone else. Call the office and ask to speak to Dr. Kaufman's nurse if your pain is not controlled.

4. When calling West Cancer Center in regards to your pain management or for prescription refills, please indicate that you are a patient of Dr. Kaufman.

5. Please note that for prescriptions refills you must call during the business day (Monday - Friday) between the hours of 9:00 am and 3:00 pm (excluding holidays). Please be certain to note that many pain medications cannot be called in by phone and will need a written prescription. Inasmuch, some prescriptions will need to be mailed or picked up at West Cancer Center and as a consequence take several days to refill. Please try to anticipate your medication needs and call us early for refills **901-683-0055**.

6. Many prescribed medications can have serious side effects and are lethal if not used as directed. You should therefore be certain to store and safe-keep all medications from others, including children and pets. Be certain to know, some medications do impair your judgement and/or your ability to operate motor vehicles or heavy machinery and equipment. Accordingly, you are instructed not to drive or perform other tasks that require intact judgement and coordination unless we have otherwise instructed you in writing. You are advised not to drink alcoholic beverages as they can interact with the medications you may be prescribed and cause serious adverse reactions (including death). Please tell us if you are or may be pregnant to avoid potential harm to you or your baby.

7. Compliance to this agreement is expected and required for your safety. If you break any term of this agreement, Dr. Kaufman may choose to discontinue writing your pain medications.

We are honored that you have chosen to let us be apart of the team taking care of you at West Cancer Center. We will work together with you to help facilitate your care. I acknowledge receipt and confirm my understanding of the information provided above.

Print Name: _____

Signed:_____ Date: _____

Witness:_____ Date:_____

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INITIAL COMPREHENSIVE
PAIN QUESTIONNAIRE

This form is designed to compliment the Cancer Care Monitor (E Tablet). Please complete this form to the best of your ability. Your careful answers will help us to understand your pain problem and design the best treatment program for you.

You may feel concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential. No outsider is permitted to see your case record without your written permission unless we are required to do so by law (e.g., Workman's Compensation Claims).

Name _____
Last First Middle

Referring Physician _____

Date of Birth _____ Age _____ Date _____

CHARACTERISTICS OF PAIN

1. What is the main problem for which you are seeking treatment?

_____

_____

_____

_____

Patient Name _____

Chart Number _____

2. Other issues or concerns:

   a. _____

   b. _____

PAIN DURATION

How long have you had your current pain problem?

_____ years _____ months _____ weeks _____ days

ONSET OF PAIN

How did your current pain start?

- ❑ Treatment caused (e.g., radiation, surgery, etc.)
- ❑ Illness
- ❑ Was there a precipitating event?
  What was it?

  _____

- ❑ Other

  _____

TIMING OF PAIN

How often do you have your pain? (please check one)

- ❑ Constantly (100% of the time)
- ❑ Nearly constantly (60% to 95% of the time)
- ❑ Intermittently (30% to 60% of the time)
- ❑ Occasionally (less than 30% of the time)

In general, during the past month when has your pain been the worst? (please check one)

❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ No Typical Pattern

Patient Name _____

Chart Number _____

PAIN LEVEL

Rate your pain by circling the number that best describes your pain at its **worst** in the last month.

0 1 2 3 4 5 6 7 8 9 10

Rate your pain by circling the number that best describes your pain at its **least** in the last month.

0 1 2 3 4 5 6 7 8 9 10

Rate your pain by circling the number that best describes your pain on **average** in the last month.

0 1 2 3 4 5 6 7 8 9 10

Rate your pain by circling the number that best describes your pain **right now**.

0 1 2 3 4 5 6 7 8 9 10

PAIN PATTERN

Some patients have pain that is present all the time, other patients have "episodes" of pain that come and go, and some have a combination of constant and episodic pain. Which of the following pain patterns is most like your own? (please circle one)

Do you have pain that is most of the time?

Do you have pain that comes and goes with very little or no pain in between?

Do you have some pain that is with you all the time also some pain that comes and goes?

PAIN QUALITY

How would you describe the pain? (please mark all that apply)

❑ sharp ❑ pins and needles ❑ burning ❑ cutting ❑ throbbing

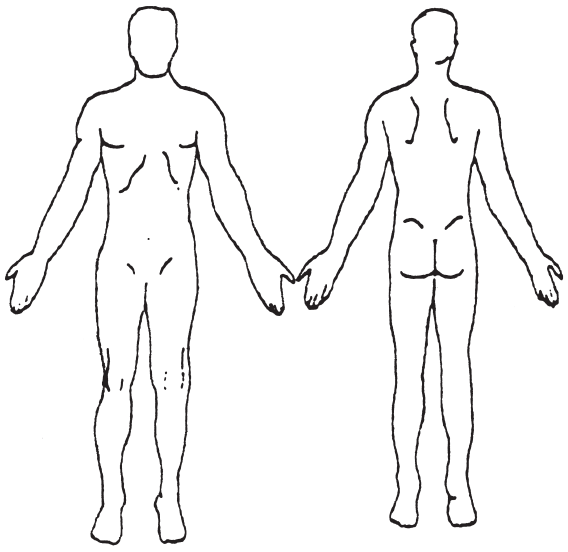
❑ cramping ❑ numbness ❑ shooting ❑ dull, aching ❑ pressure ❑ other

Patient Name _____

Chart Number _____

PAIN LEVEL

Please mark the location(s) of your pain on the diagrams below with an "X."
If whole areas are painful, please shade in the painful area.



front *back*

PAIN QUALITY

How do the following affect your pain? (please check one for each item)

	Decrease	Increase	No Change
Lying down	❑	❑	❑
Standing	❑	❑	❑
Sitting	❑	❑	❑
Walking	❑	❑	❑
Exercise (if applicable)	❑	❑	❑
Medications	❑	❑	❑
Relaxation	❑	❑	❑
Thinking about something else	❑	❑	❑
Coughing/Sneezing	❑	❑	❑
Urination	❑	❑	❑
Bowel movements	❑	❑	❑
Cold	❑	❑	❑
Heat	❑	❑	❑
Other _____	❑	❑	❑

Patient Name _____

Chart Number _____

MEDICATION SIDE EFFECTS/SYMPTOMS

What **side effects** or **symptoms** are you having? Circle the number that best describes your experience during the past week.

a.	nausea	0	1	2	3	4	5	6	7	8	9	10
b.	vomiting	0	1	2	3	4	5	6	7	8	9	10
c.	constipation	0	1	2	3	4	5	6	7	8	9	10
d.	lack of appetite	0	1	2	3	4	5	6	7	8	9	10
e.	tired	0	1	2	3	4	5	6	7	8	9	10
f.	itching	0	1	2	3	4	5	6	7	8	9	10
g.	nightmares	0	1	2	3	4	5	6	7	8	9	10
h.	sweating	0	1	2	3	4	5	6	7	8	9	10
i.	difficulty thinking	0	1	2	3	4	5	6	7	8	9	10
j.	insomnia	0	1	2	3	4	5	6	7	8	9	10

Circle the number that describes how during the past week pain has **interfered** with your:

a.	general activity	0	1	2	3	4	5	6	7	8	9	10
b.	mood	0	1	2	3	4	5	6	7	8	9	10
c.	normal work	0	1	2	3	4	5	6	7	8	9	10
d.	sleep	0	1	2	3	4	5	6	7	8	9	10
e.	enjoyment of life	0	1	2	3	4	5	6	7	8	9	10
f.	ability to concentrate	0	1	2	3	4	5	6	7	8	9	10
g.	relations with other people	0	1	2	3	4	5	6	7	8	9	10

Patient Name _____

Chart Number _____

CURRENT MEDICATIONS

(current), prescription, non-prescription, herbal, etc. (check all that apply)

Name	Dose	AM	Afternoon	Evening
_____	_____	❑	❑	❑
_____	_____	❑	❑	❑
_____	_____	❑	❑	❑
_____	_____	❑	❑	❑
_____	_____	❑	❑	❑
_____	_____	❑	❑	❑
_____	_____	❑	❑	❑
_____	_____	❑	❑	❑
_____	_____	❑	❑	❑
_____	_____	❑	❑	❑

ALLERGIES

Please indicate the names of any medications that you are allergic to in the space below:

_____

_____

MEDICATIONS PRESCRIBED IN THE PAST FOR PAIN:

_____

_____

SLEEP QUESTIONS

Average number of hours sleep per night _____

Do you have difficulty falling to sleep?	❑ Yes	❑ No
Do you have difficulty remaining asleep?	❑ Yes	❑ No
Do you awaken refreshed?	❑ Yes	❑ No
Are you ever awakened by the pain?	❑ Yes	❑ No

Patient Name _____

Chart Number _____

PAIN TREATMENTS

Please check all of the treatments you have tried for your pain and then complete the appropriate column to the right to the best of your ability.

Treatment	Date (approx)	No Relief	Moderate Relief	Good Relief	Have Not Used
Medications	_____	❑	❑	❑	❑
Nerve block or other	_____	❑	❑	❑	❑
Injections	_____	❑	❑	❑	❑
Pain Clinic	_____	❑	❑	❑	❑
Psychiatrist / Psychologist	_____	❑	❑	❑	❑
Bed Rest	_____	❑	❑	❑	❑
Surgery	_____	❑	❑	❑	❑
Physical therapy	_____	❑	❑	❑	❑
Hypnosis	_____	❑	❑	❑	❑
Acupuncture	_____	❑	❑	❑	❑
TENS	_____	❑	❑	❑	❑
Exercise	_____	❑	❑	❑	❑
Biofeedback	_____	❑	❑	❑	❑
Chiropractor	_____	❑	❑	❑	❑
Other	_____	❑	❑	❑	❑

Details _____

PSYCHOLOGICAL TREATMENT

Have you ever had psychiatric, or social work evaluations or treatments for any problem, including your current pain? ❑ Yes ❑ No If yes, list provider, date and comments.

_____

_____

Patient Name _____

Chart Number _____

FAMILY LIFE

Living arrangements: ❑ living alone ❑ living with friends ❑ living with children
❑ living with spouse/partner ❑ living with spouse/partner and children ❑ living with other

SUBSTANCE ABUSE

Do you have or have you ever had a problem with Alcoholism?	❑ Yes	❑ No
Do you have or have you ever had a problem with drug abuse? (prescription or illicit)	❑ Yes	❑ No
Are you now or have you ever been in a detoxification program for drug abuse?	❑ Yes	❑ No
Alcoholics Anonymous or other twelve step program?	❑ Yes	❑ No

Thank you for taking the time to fill out this form. We will review it with you. Please feel free to call us if you have any other concerns that are not addressed here.

Seth I. Kaufman, M.D.
Pain and Palliative Care
West Cancer Center

The University of Tennessee
WEST
Cancer Center
Methodist Healthcare Family

WEST CANCER CENTER
Authorization For West Cancer Center to obtain Your medical records from other care providers

"Patient, please complete and sign this form so we can request your records from other providers"

TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

I,_____, Date of Birth_____do hereby authorize West Cancer Center to obtain, use, disclose or receive my individually identifiable health information as described below :

FROM: Any of my healthcare providers or institutions containing records pertinent to my care

ATTENTION: PATIENT OR PATIENT REPRESENTATIVE PLEASE CHOOSE AND INITIAL A OR B

X **A** **Complete medical record** which may contain treatment notes regarding radiology, pathology ***(including HIV test results and genetic testing information),*** immunization, procedure(s), ***alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2,*** and other common medical record documentation by the physician, nurse or other ancillary personnel for the entire time I was treated by the practice.

_____ **B** For information collected/services described below and provided **during the time period of :** _____

_____

Description of records to be released: _____

_____

TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

Release my records to

ATTN: West Cancer Center

For the purpose(s) of: Treatment, Payments or Operations

I understand that I may withdraw my authorization in writing to West Cancer Center at any time, except to the extent that action has been taken in reliance on this statement. I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to West Cancer Center. If this authorization has not been revoked, and if I have not indicated an expiration date, this authorization will expire one year from the date of execution.

- **YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED.**
- **YOU MAY REFUSE TO SIGN THIS FORM**
- **WE MUST PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST**
- **I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY**

_____ _____

Signature of patient or patient's representative **Date**

(Form MUST be completed before signing.)

Printed name of patient's representative _____

Description of the Representative's authority to act in behalf of the patient _____

Relationship to the patient: _____

*For information about how your medical information may be used or disclosed, please see the Patient Notice.