IEHP Pain Assessment & Treatment Plan

Patient Name: **Member ID:**

Date of Birth: **Diagnosis**

*****Please complete ALL sections of this form for further consideration. Incomplete forms will not be taken. *****

Section A:
Member Medication Regimen

Current Analgesic Regimen:

Drug Name	Strength	Frequency	Quantity	Duration	D/C date

Past Analgesic Regimen (within last 6 months):

Drug Name	Strength	Frequency	Quantity	Duration	D/C date

Section B:
Supporting documents for current treatment plan.

___ Chart notes documenting titration up to current dose.

___ Documentation indicating that the risk and benefits of opioid therapy have been discussed with the patient.

___ Documentation indicating treatment plan for discontinuation if benefits do not outweigh the risks.

___ Documentation indicating a Prescription Drug Monitoring Report (CURES) has been reviewed in the past 3 months.
Date CURES report was accessed: _____

___ Pain Contract signed and dated within the past 12 months.
Date Pain Contract was signed: _____

___ Urine Drug Screen within the past 6 months.

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Date Urine Drug Screen was taken: _____ **Results of test: _____**

Section C: **Treatment Assessment Questions**	
Has the patient tried the most optimal non-opioid containing analgesic drug regimen?	Yes __ No__
Does the patient have any history of substance abuse? If yes, please identify the substance and past treatment	Yes __ No__
Please provide any additional medical justification relevant to adding this medication to the patient's pain regimen.	Yes __ No__

Section D: **Pain Assessment (0 = no pain, 10 = worst pain)**
Current Pain: On a scale of 0-10, how would you assess patient's current pain. Please circle one: 0 1 2 3 4 5 6 7 8 9 10 Comments:_____
Treatment Goal: On a scale of 0-10, what is the pain scale goal for this patient. Please circle one: 0 1 2 3 4 5 6 7 8 9 10 Comments:_____