Medication Refill Policy

In an effort to enable our nursing staff time to respond quickly & effectively to patients who need immediate assistance, Pain Management has adopted the following policy for refilling medications. Please review and save for future reference.

It is your responsibility to be sure ALL prescriptions that you will need to last you until your next visit are written by the physician, even if you are not yet running low. Keep a list of all medications with you to review with the physician during your visit.

Effectively immediately prescription HOT LINE VOICE MAIL(609 430 7757) is available for your prescription needs. Organize your mediation needs so that you can request everything you need in one phone call. Do not wait until you are out of medication – prescriptions cannot be filled on the weekend.

Prescribed medication that is lost/discarded by the patient **WILL NOT** be replaced.

REMEMBER: PRESCRIPTIONS FOR NARCOTIC MEDICATIONS CANNOT BE CALLED INTO THE PHARMACY.

PRESCRIPTION REFILLS REQUIRE 2 BUSINESS DAYS TO BE FILLED.

1. To use the HOT LINE please leave the following: name, telephone number, name of mediation, name of pharmacy and pharmacy phone #, or tell us if you will be using a mail order pharmacy. Also indicate when you will be picking up prescription.
2. Prescription line is available 24 hours a day, but requests will only be retrieved Monday – Friday between 8:30 A.M. & 3:00 P.M.
3. The prescription will automatically be written, do not call to check if the refill has been called to the pharmacy. Call the pharmacy first, that way you will find out if it is ready. We will only call you if there is a problem.
4. Please do not call us & the pharmacy – the pharmacy will then call us & we will have two requests, which doubles our work and creates confusion.
5. If you are using as Mail Order Pharmacy – please arrange to pick up & mail your prescriptions. We can no longer telephone prescriptions to mail order pharmacies.
6. If you call the Pain Management Office for prescription requests, the office staff has been instructed to transfer you to the prescription HOT LINE.

System Review & Past Medical History

Name:______________________________________ Date of Birth: ____________

From the following list, please check any symptoms or conditions that apply to you.

SKIN:	HEART & CIRCULATION:	KIDNEYS/URINARY TRACT:
[ ]rashes, psoriasis, dermatits	[ ] heart attack	[ ] kidney disease or failure
[ ] history of skin cancer	[ ] hypertension -high blood pressure	[ ] history of kidney dialysis
[ ] new skin growth or mole	[ ] heart murmur	[ ] kidney stones or infection
EYESI	[ ] chest discomfort (angina) with	[ ] pain or burning with urination
[ ] wear glasses	physical activity	[ ] trouble starting urine stream
[ ] wear contact lenses	[ ] heart failure or fluid on lungs	[ ] dribble or incontinence
[ ] permanent blindness(either eye)	[ ] palpitations/racing or pounding	[ ] multiple trips to the bathroom to
[ ] Cataracts	heartbeat	Urinate at night
[ ] Glaucoma	[ ] stroke	[ ] bladder infections during past yr.
EARS/NOSE/THROAT	[ ] blood clot in artery or vein	[ ] blood in urine during past yr.
[ ] loss of hearing	[ ] Mini-strokes or TIA's	[ ] prostate disease
[ ] hearing aids – [ ]Yes [ ]No	[ ] black out spells	MUSCLES/JOINTS/BONES:
[ ] ringing in ears	[ ] aneurysm or any blood vessel	[ ] Arthritis or other joint disease
[ ] frequent earaches	[ ] frequent ankle swelling at	[ ] chronic back trouble
[ ] discharge from ear	bedtime	[ ] bone or joint surgery in past yr.
[ ] attacks of vertigo	[ ] heart surgery	NERVOUS SYSTEM:
[ ] frequent sinus infections	STOMACH/INTESTINES:	[ ] Migraine headaches
[ ] nasal blockage	[ ] stomach ulcer or peptic ulcer	[ ] Epilepsy or seizures
[ ] frequent sneezing	[ ] frequent heartburn/indigestion	Date last seizure:
[ ] frequent sore throat	[ ] Hiatal hernia or acid reflux	[ ] Depression
[ ] loud snoring	[ ] poor appetite	[ ] other nervous disorder
[ ] recent change in voice quality	[ ] gall bladder attacks	Specify:
[ ] sleep apnea	[ ] frequent diarrhea	BLOOD:
[ ] difficulty swallowing	[ ] chronic constipation	[ ] bleeding or bruising tendency
[ ] frequent headache	[ ] bright blood from bowel/rectum	[ ] previous blood transfusion
[ ] nose bleeds	[ ] dark tarry stools	[ ] history of hepatitis
[ ] exposure to loud noise	[ ] liver disease or jaundice	
RESPIRATORY:	ENDOCRINE/METABOLISM	REPRODUCTIVE(Women only):
[ ] Asthma or wheezing	[ ] Thyroid disease	Are you or might you be pregnant?
[ ] recent bronchitis or chest cold	[ ] recent weight gain or loss	[ ] Yes [ ] No
[ ] cough for over past 2 months	(more than 10 lbs.)	
[ ] coughing up blood	[ ] Diabetes	
[ ] shortness of breath		

Please circle the following diseases if your family members (blood relatives) have experienced them:

Diabetes Cancer High Blood Pressure Allergy Hearing Loss Stroke Bleeding Disorder

List any other illness that runs in your family:____

Do you have any other special concerns or additional information we should be aware of regarding your care?

Please sign below after you have completed this form to the best of your ability and knowledge.

Signature:______________________________________ Date: ______________

NEW PATIENT DEMOGRAPHIC INFORMATION

NAME: ____

Address: ____

Phone Number(s):Home ____________________ Cell ____________________

E-Mail Address: ____

Emergency Contact: Name: ______________________ Relationship ________

Telephone: ______________________________

Referring Physician: Name: ______________________________

Address: ______________________________

Phone# ____________________ Fax# ________________

Primary Care Physician: Name: ______________________________

Address: ______________________________

Phone# ____________________ Fax# ________________

INSURANCE:

Primary Insurance: ______________________________________

Insured Name: ____________________ ID#: ____________________

Provider Services Phone #: ______________________________

Secondary Insurance: ______________________________________

Insured Name: ____________________ ID#: ____________________

Provider Services Phone #: ______________________________

PRINCETON PAIN MANAGEMENT: Update of Medication List **Pt.Name**______________________________

Allergies:____

In Medication Column list name(s) of **ALL** medication, strength (ie. mgs), route (pills, pathes,inhalers,etc.)

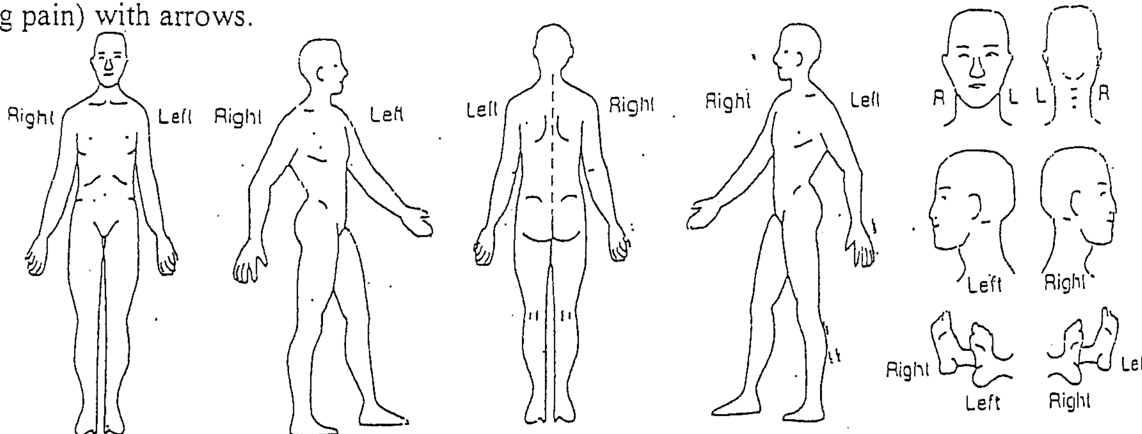
MEDICATION	DOSE	FREQUENCY	LAST DOSE TAKEN	REASON TAKING MEDICATION

Initial Consult (forms 2007)

Patient Name:
Age:

My main complaint(s):____

Please mark the appropriate locations on the diagrams below. Please indicate where the pain goes (radiating pain) with arrows.



Duration of Pain: ____

Nature of Pain: ( ) Constant ( ) Intermittent

Quality of Pain:

Please mark all that apply:

( ) Throbbing ( ) Cramping ( ) Gnawing ( ) Aching ( ) Shooting
( ) Stabbing ( ) Sharp ( ) Hot-burning ( ) Heavy ( ) Tender
( ) Splitting ( ) Sickening ( ) Heavy

Other ____

Intensity of Pain:

On a scale of 0-10, with 10 being the worst imaginable pain and 0 the absence of pain; how would you rate your pain:

At Worst:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10
Average:	0	1	2	3	4	5	6	7	8	9	10

What makes your pain worse?

( ) Bending ( ) Lifting ( ) Coughing ( ) Sneezing ( ) Defecation
( ) Sexual Intercourse ( ) Prolonged Sitting ( ) Prolonged Standing ( ) Walking

Other: ____

In what time period is your pain worse? ( ) early morning ( ) late evening

What makes your pain better?

( ) Rest ( ) Activity/physical therapy ( ) Massage ( ) Heat
( ) Cold ( ) Lying in fetal position ( ) Lying on your back
( ) Medication ____

Other: ____

Review of Systems:

- **Constitutional** ( ) Fever ( ) Fatigue

- ☐ Difficulty getting to sleep
- ☐ Difficulty staying asleep
- ☐ Non-restful sleep
- ☐ Excessive fatigue
- ☐ Daytime sleepiness
- ☐ Difficulty concentrating
- ☐ Headache
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Urinary retention
- ☐ Painful intercourse
- ☐ Diminished libido
- ☐ Medication side effects ______________________________
- ☐ Weakness ______________
- ☐ Numbness/Tingling
- ☐ Diminished endurance
- ☐ Increased appetite
- ☐ Weight gain: ______ pounds
- ☐ Decreased appetite
- ☐ Weight Loss: ______ pounds
- ☐ Irritability
- ☐ Tearfulness
- ☐ Anxiety
- ☐ Depression
- ☐ Suicidal thoughts
- ☐ Incontinence

Additional Comments: ______________________________

____

____

Treatment History:

	% Improved Pain	Aggravates Pain	No Change	Unknown
Injections (Epidural, trigger point, etc)	[ ]%	[ ]	[ ]	[ ]
Physical Therapy	[ ]	[ ]	[ ]	[ ]
Aquatic Therapy	[ ]	[ ]	[ ]	[ ]
TENS Unit	[ ]	[ ]	[ ]	[ ]
Massage	[ ]	[ ]	[ ]	[ ]
Chiropractor	[ ]	[ ]	[ ]	[ ]
Exercise	[ ]	[ ]	[ ]	[ ]
Biofeedback	[ ]	[ ]	[ ]	[ ]
Acupuncture	[ ]	[ ]	[ ]	[ ]
Other				

____

____

____

Additional Comments: ______________________________

____

____

Please mark the medications that you have tried in the past and their effectiveness
(0 – no help - 10 – very helpful):

Name of medication	Effectiveness (0-10)
[ ] Tylenol	________
[ ] NSAID's: Motrin/Advil?Ibuprofen, etc.	________
[ ] Opioids: Vicodin/Norco/Oxycodone, etc.	________
[ ] Oral steroids/Medrol dose pack	________
[ ] Amitriptyline (Elavil), Nortriptyline (Pamelor), etc.	________
[ ] Neurontin/Topamax/Tegetrol, etc.	________
[ ] Others (muscle relaxers, etc)	________

- **Social History/Family History**
  Occupation: ______________________ Marital Status: ________________
  Education: ______________________ On Disability: ( ) Yes ( ) No
  Use of tobacco: (type & how long) ______________________
  Use of alcohol: (type & how long) ______________________
  Use of Recreational drugs: (type & how long) ______________________
  What diseases are in your family______________________

- **Past Medical History:**

  Name of Illness — Duration

  ____
  ____
  ____

- **Past Surgical History:**

  Name of Surgery — Date

  ____
  ____
  ____

- **Allergies: (medical/environmental/etc.)**

  ____

Patient Signature______________________ Date ________________

Compiled by Patient/Nurse

Reviewed by Practitioner: ______________________
(Signature)

CONSENT AND AUTHORIZATI0N

Name of Patient:________________________________ Date of Birth: _____________

Address:____

City:________________________ State: ______ Zip Code: ___________

CONSENT TO TREATMENT:
I hereby voluntarily consent to treatment at Princeton Pain Management (PPM) and authorize each of its physicians, practitioners and authorized employees to render medical care. I understand that the medical care that I receive at this facility may include, laboratory tests, diagnostic procedures, therapy, examinations and administration of medications. I understand and acknowledge that no guarantees have been made to me about the outcome of my care.

____________________________________ ____________________
Patients Signature Date

or, IF NOT SIGNED BY PATIENT:

____________________________________ ____________________
Patient's Legal Representative Date

____
Relationship to Patient

FINANCIAL AGREEMENT:
In consideration of services to be rendered by PPM I hereby authorize my health care insurer to pay PPM directly for covered services. I accept sole responsibility for all charges incurred as a result of services rendered and agree to pay amounts not covered by insurers. I hereby agree to all pre-certification requirements as stated in my health insurance policy. I understand that I am financially responsible for any charges not covered by my health insurance benefits.

RELEASE OF RESPONSIBILITY FOR VALUABLES/BELONGINGS RETAINED BY PATIENT:
I understand that PPM is not responsible for the loss or damage to any valuables or personal articles which I retain at PPM. These items should be left with family/friend and I will accept full responsibility for items that I retain in my possession.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Authorization:

[ ] I hereby authorize the release of information contained in the Medical Records of the above names patient. This information is to be released to:

PRINCETON PAIN MANAGEMENT
281 Witherspoon Street
Princeton, NJ 08540

and/or

[ ] I acknowledge and accept the release of Medical Records regarding ongoing treatment at Princeton Pain Management when authorized by my signature.

I understand that I have no obligation to disclose any information from my medical record other than to my referring physician. I also understand that I may revoke my consent by notifying Princeton Pain Management in writing except to the extent that action has been taken based on this authorization.

X____

Date Patient Signature

X____

Date Witness

ACKNOWLEDGEMENT

I hereby acknowledge that I have read (or had it read to me) and understand this form and any questions I had were answered to my satisfaction. I hereby agree and accept the terms of this form.

( ) I hereby acknowledge I received the Patient Rights.

______________________________ ______________

Patient's Signature Date

OR IF NOT SIGNED BY PATIENT:

______________________________ ______________

Signature of Patient's Legally Authorized Representative Date

____

Relationship to Patient

CONSENT BY PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE

(If patient is unable to consent or is a minor, complete the following)

( ) Patient is a minor________ years of age

( ) Patient is unable to consent because ______________________________

______________________________ ______________________________

Signature of Patient's legally authorized representative Signature of Witness