UW TelePain Case Consultation Request Form

UW Medicine - Pain Medicine

Please complete ALL ITEMS on this form.
Wednesday cases should be faxed to Cara Towle at 206-598-4576.
Thursday cases should be emailed to Deb Gordon at debrag3@uw.edu.

Provider First Name:	
Provider Last Name:	
Provider Phone Number (for phone follow-up):	
Provider email:	
Provider Fax Number (where medical records & follow-up can be sent):	
Clinic/Facility Name:	
Clinic/Facility Street Address:	
Clinic/Facility Zip Code:	
Clinic/Facility City and State:	

UW TelePain is on Wednesday and Thursday, noon to 1.30pm
On which day and date (1st and 2nd choice) would you like to present this case? _____

Reason for Consultation (check all that apply)	☐ Need assist with pain diagnosis ☐ Confirmation of continuing stable opioid dose ☐ Request to increase opioid dose ☐ Seek advice on opioid rotation ☐ Request for taper plan to decrease opioid dose ☐ Aberrant behavior, confirmation to discontinue opioids ☐ Seek advice regarding adjuvant analgesics ☐ Seek advice regarding non-pharmacologic strategies ☐ Poor pain control, seek general advice on what to do

Other Questions and Areas of Concern that you would like to discuss in the Telemedicine conference?

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Rev 2-2-2015

UW Medicine: TelePain CHRONIC PAIN IN PRIMARY CARE

Date:_____

Year of Birth _____ Gender [ ] Male [ ] Female Ht _____ Wt in lbs _____ BMI ____

RACE

[ ] American Indian/Alaska Native
[ ] Asian
[ ] Black or African American
[ ] Native Hawaiian/Pacific Islander
[ ] White

ETHNICITY

[ ] Hispanic / Latino
[ ] Not Hispanic/Latino

CHECK OFF LIST

[ ] Review of prescription monitoring program (PMP), ED or Pharmacist info
[ ] Informed consent
[ ] Signed pain agreement
[ ] Signed release for MH and Substance Abuse

SOCIAL SITUATION

[ ] single
[ ] married
[ ] divorced [ ] separated
[ ] widowed
[ ] co-habitation
[ ] housing unstable
[ ] homeless
[ ] other _____

[ ] Medicaid
[ ] Medicare
[ ] Private insurance
[ ] Uninsured
[ ] Workman's comp case

ACTIVITY ENGAGEMENT

[ ] Work full time
[ ] Work part time
[ ] Unemployed because of pain
[ ] Unemployed (not because of pain) e.g. homemaker
[ ] Retired early because of pain
[ ] Retired (not because of pain)
[ ] Volunteer
[ ] Mental Health counselor
[ ] Parole officer plan
[ ] Chemical dependency TX
[ ] AA
[ ] NA
[ ] I need assistance for personal care
[ ] other _____

CURRENT (RELEVANT) MEDICATIONS

Opioids:

Length of chronic opioid therapy: ___ Years _____ Months

Current Non-opioids:	
NSAIDs	
Antidepressants	
Antiepileptics	
Muscle relaxants	
Sleep medications	
Behavioral health	
Physical therapy	
Injections	
Acupuncture	
Addiction	
Other relevant:	

Other pain related treatments / interventions underway (or planned):

Morphine Equivalent Dose (MED) _____

For online morphine dose calculator see:

http://www.agencymeddirectors.wa.gov/opioiddosing.asp

OPIOID RISK TOOL(ORT)

(√ applicable box and total column)

	Male	**Female**
Family history (parents and siblings):		
Alcohol abuse	_____(3)	_____(1)
Illegal drug use	_____(3)	_____(2)
Prescription drug abuse	_____ (4)	_____(4)
Personal history:		
Alcohol abuse	_____(3)	_____(3)
Illegal drug use	_____(4)	_____ (4)
Prescription drug abuse	_____(5)	_____(5)
Mental health:		
Dx of ADD, OCD, bipolar, schizophrenia	_____(2)	_____(2)
Diagnosis of depression	_____ (1)	_____(1)
Other:		
Age 16-45 years	_____ (1)	_____(1)
History of pre-adolescent sexual abuse	_____ (0)	_____(3)
Total Score:	_____	_____

ORT Scoring:

0-3 = low risk: 6% chance of developing problematic behaviors
4-7 = moderate risk: 28% chance of developing problematic behaviors
>= 8 = high risk: >90% chance of developing problematic behaviors

MEDICAL HISTORY AND EXAM FINDINGS

Co-morbidities that may affect pain treatment decisions

(May attach medical chart problem list.)

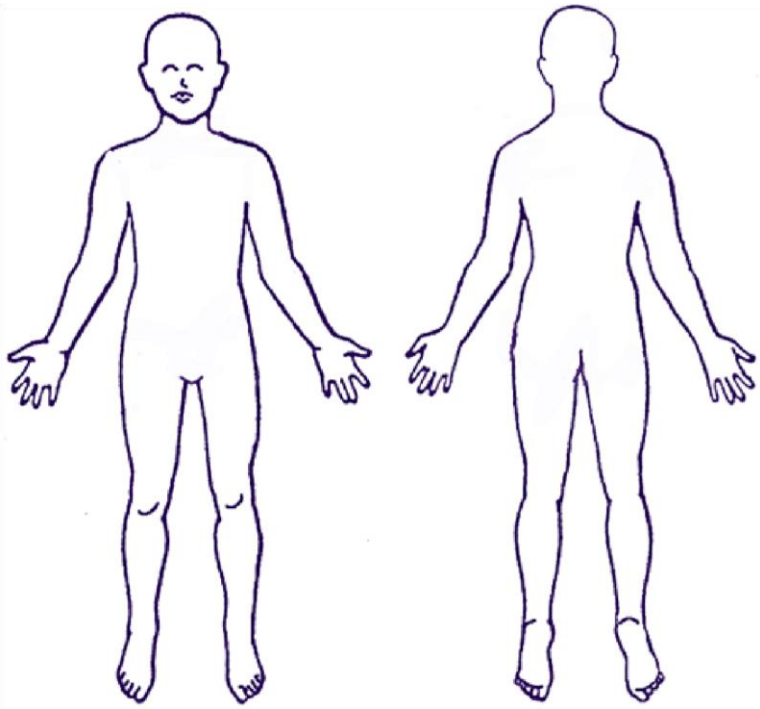
History or risks **falls or fractures**?	☐ Yes	☐ No
Sleep Apnea or respiratory disease	☐ Yes	☐ No
Tobacco Use?	☐ Yes	☐ No
History of **Seizures**?	☐ Yes	☐ No
History of other **abuse**, sexual assault, domestic violence, other trauma?	☐ Yes	☐ No
Psych hospitalizations or suicide attempts?	☐ Yes	☐ No

Allergies:

LAB/IMAGING/DIAGNOSTICS

UDT	**Date**	**Result**
UDT		
HCV		
HIV		
Creatinine		
ALT/AST		
Pregnancy Test		
B12		
Vit D		
Other		
Imaging		

TelePain ID # T-
PAIN DIAGNOSES (or cause of pain if known): _____
DURATION OF SYMPTOMS (precipitating if known): _____
PAIN LOCATION(S)
Body Diagram Instructions – Please mark all pain locations and (*) star worst pain location. Check all boxes below that apply.



Characterization of pain (check all that apply):	
☐ Musculoskeletal	☐ Unifocal
☐ Visceral	☐ Multifocal
☐ Neuropathic	
Body Diagram Instructions: Mark all pain locations	
Place a (*) on the worst pain locations	
Body Diagram completed by patient (preferred) ☐ Yes ☐ No	
Body Diagram completed by provider ☐ Yes ☐ No	

PAIN MANAGEMENT TREATMENT HISTORY: (past treatment, what works, what doesn't? ALLERGIES or intolerances? compliance with treatment?

Therapy	**Tried (approx. date)**	**Still Using**	**Why stopped, comments**
Acupuncture			
Antidepressants			
Cognitive-Behavioral Therapy/Counseling			
Gabapentin/Pregabalin			
Injections			
Massage			
NSAIDs			
Opioids			
Physical Therapy/exercise			
Spinal cord stimulator			
TENS			
Topicals			
OTHER			

TelePain ID # T-

TRACKER: ***Please ask PATIENT to provide*** the one number that best describes [his/her] pain on the **average** in the last week?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

Fill in the circle of the one number that describes how, during the past week, **pain has interfered** with your:

General activity

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Enjoyment of life

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Falling asleep

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Staying asleep

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Please list one important activity that is difficult for you to perform so that we can monitor it during your pain treatment. **Activity (describe):** _____. How would you rate the **difficulty** you have had **doing this activity** over the past week? Can do with…

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
No Difficulty										Extreme difficulty

Over the past 2 weeks, have you been bothered by these problems?

	Not at all	Several days	More days than not	Nearly every day
	0	1	2	3
Feeling nervous, anxious, or on edge	○	○	○	○
Not being able to stop or control worrying	○	○	○	○
Feeling down, depressed, or hopeless	○	○	○	○
Little interest or pleasure in doing things	○	○	○	○
TOTAL SCORE _____ =	___+	___+	___+	___

Are you having any **side effects** from any of the medications you take for pain ____Yes ____ No

If yes, what is the most bothersome side effect? _____Please circle the number that best shows the **severity of the most bothersome side effect**:

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
None										Severe

In the past month, how many **"bad days"** have you had where you **needed to take more pain** medication than your doctor is currently prescribing? ____None ____1-2 days ____3-5 days ____More than 5

Please fill in the circle of the one number that best shows how **satisfied** you are with the **results of your pain treatment**:

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
Extremely Dissatisfied										Extremely Satisfied