# 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 |
|---|---|---|---|---|---|
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**Past Analgesic Regimen (within last 6 months):**

| Drug Name | Strength | Frequency | Quantity | Duration | D/C date |
|---|---|---|---|---|---|
| | | | | | |
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| | | | | | |
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## 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 within the past 30 days.
**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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**Patient Name:** **Member ID:**

**Date of Birth:** **Diagnosis**

| **Date Urine Drug Screen was taken: ______**<br>**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?<br>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:**<br>On a scale of 0-10, how would you assess patient's current pain.<br>Please circle one: 0 1 2 3 4 5 6 7 8 9 10<br>Comments:____________________________________________________________ |
| **Treatment Goal:**<br>On a scale of 0-10, what is the pain scale goal for this patient.<br>Please circle one: 0 1 2 3 4 5 6 7 8 9 10<br>Comments:____________________________________________________________ |