THE NURSE'S OFFICE
Primary Care & Walk-in Center

Address: 179 Linwood Ave. Colchester, CT 06415 Phone: (860) 603-3541 Fax: (860) 603-3544
Visit Date: / /
MR#: _____

Patient Application for Treatment

1. Name: _____ **2. Date of Birth:**_____ **3. Social Security #:** _____

2. Address: _____ **City:** _____**Zip Code:** _____

4. Gender: M___F___Transgender____ Other____ **5. Married?** ❑ Yes ❑ No **6. Number of children at home?**_____

7. Home: _____ **8. Cell:** _____ **9. Email Address:** _____

10. Insurance Name and ID #: _____ **11. Is this injury a Workers Comp case or MVA? Y N**

If so please list your attorney's contact information or Work Comp case manager: _____

12. Pharmacy Name and Address: _____
13. Emergency Contact Name and Number:_____

14. Have you ever been arrested or convicted of any drug related charges including narcotics? (Y N) If you answered Yes please provide date of arrest and what the charges were: _____

15. Are you capable of making your own medical decisions? Y / N if no, who is your care taker? _____
Race:_____ **Ethnicity**_____

16. How did you hear about us?_____

CC

Please identify the problem areas:

Complaint	**Intensity of Pain** (1-10)	**Description:** (dull ,sharp ,burning ,stiff)	**Frequency:** (constant, frequent, occasional, on/off)
Headache	1 2 3 4 5 6 7 8 9 10		
Neck Pain	1 2 3 4 5 6 7 8 9 10		
Shoulder(s)	1 2 3 4 5 6 7 8 9 10		
Mid-Back	1 2 3 4 5 6 7 8 9 10		
Low-Back	1 2 3 4 5 6 7 8 9 10		
Hip(s)	1 2 3 4 5 6 7 8 9 10		
Extremities (hands/feet)	1 2 3 4 5 6 7 8 9 10		
Other:	1 2 3 4 5 6 7 8 9 10		

HPI

My pain was brought about as a result of: ❑ an accident ❑ medical/ surgical procedure ❑ injury ❑ without obvious cause

Which occurred approximately ____weeks _____months _____years ago.

Pain is worse in the: ❑ morning ❑afternoon ❑ evening ❑ late at night ❑always the same

What makes the pain worse? _____

Besides medication is there anything that seems to help lessen the pain? ❑ NO ❑ YES If yes what?

_____

Have you been treated by anyone else for your problem? ❑ No ❑ Yes If yes by whom?

_____

How often have you been treated for an alcohol or drug problem? ❑Never ❑seldom ❑sometimes ❑often

How often do you present to the emergency room: ❑never ❑seldom ❑sometimes ❑often

List **ALL** mediations you are **currently** taking in the chart below:

Medications:	Date prescribed Last refill:	Dose:	How often you take this Medication:
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Past History

LIST ALL:

Injuries: _____

Illnesses: _____

Surgeries: _____

Allergies: _____

Social

What is your level of education: _____

Complete the chart below by putting an **"X"** under the column that best describes your use of tobacco, alcohol caffeine and drugs

FREQUENCY USE	ALL DAY EVERY DAY	DAILY	WEEKLY	OCCASIONALLY	RARELY
Example:					
TOBACCO	X				
TOBACCO					
ALCOHOL					
CAFFEINE					
Recreational DRUGS (Identify specifically)					

Family History

Have any family member(s) suffer same or similar type of problem(s) that you are seeking treatment ❑ No ❑ Yes

If yes who? ❑ Mother ❑ Father ❑ Sibling(s) ❑ Grandfather ❑ Grandmother

_____

Patient Signature ***Date***

Informed Consent and Agreement for Treatment

I, _____, understand and agree to follow the policies of The Nurse's Office, as set forth below. I understand that The Nurse's Office is under no obligation to prescribe these medications for me. I also understand that there may be other, more reasonable treatment options available for my condition that my doctor may recommend instead of or in addition to the use of these medications.

DEFINITIONS OF OPIOIDS, BENZODIAZEPINES, AND OTHER CONTROLLED SUBSTANCES

I understand the definitions of these medications to be:
1. **Opioid -** An opioid medication is a derivative of morphine or similar compound and thus has strong pain relieving properties.
2. **Benzodiazepine -** A benzodiazepine is a sedative-hypnotic. Its primary role is for the treatment of anxiety.
3. **Other related drugs -** For the purposes of this agreement, "other related drugs" includes medications such as muscle relaxants (e.g., Flexeril), membrane stabilizers (e.g., Lyrica), and non-narcotic analgesics (e.g., Ultram). These medications may cause sedation, altered mental status, occasionally dangerous withdrawal effects when stopped abruptly, and may have medication interactions similar to or different from opioids or benzodiazepines.
4. **Controlled Substance -** For the purposes of this agreement, a controlled substance will apply to opioids, benzodiazepines, or other related medications as described above.

RISKS OF OPIOIDS, BENZODIAZEPINES, AND OTHER RELATED MEDICATIONS ("CONTROLLED SUBSTANCES")

I understand that these medications have potential risks with the most significant being:

1. **Physical Dependence**—Physical dependence is a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.
2. **Addiction**—Addiction is a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors Influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.
3. **Overdose**- Taking too much of one or more medications may lead to respiratory arrest and death.
4. **Altered Mental Status**- These classes of medications may cause confusion, sedation, drowsiness, problems with coordination, and changes in thinking ability. This may make it unsafe for you to drive a motor vehicle, operate hazardous equipment and machinery, or perform dangerous activities. Other side effects may include but are not limited to, the following: nausea, constipation, unsteadiness, decreased appetite, difficulty urinating, depression, and loss of sexual drive with testicular atrophy (in males).

CONDITIONS OF AGREEMENT

1. I understand that Controlled Substances may be prescribed by my physician only if he determines that such treatment has a reasonable chance of improving my quality of life, ability to participate in work activities, and social activities.
2. I do not currently have problems with substance abuse (drugs and/or alcohol).
3. I am not involved in the use, possession, diversion, or transport of illegally obtained controlled substances.

4. I agree to use these medications only as prescribed to me and will not take more of these medications than instructed. I agree to not allow other individuals to take my medication nor will I take medication prescribed to another person.
5. I understand the risk of controlled substances to unborn children and will notify The Nurse's Office if I am or become pregnant.
6. I will obtain pain medications only from The Nurse's Office and not from any other source unless a true medical emergency exists. I will notify The Nurse's Office in advance of any anticipated acute needs (dental work or surgery).
7. I agree to accept generic brands of my controlled substances if available.
8. If it appears to my physician that the use of controlled substances is not providing a demonstrable therapeutic benefit such as improvement in daily function or improved ability to participate in the treatment program, if the controlled substances being prescribed are expected to be the mainstay of pain treatment when other medical options exist and are practical, or that addiction, rapid loss of effect, or significant side effects are developing, I agree to taper my medication as directed. If a substance abuse problem is suspected, I understand that I may be referred for evaluation and management of the problem.
9. I agree to keep my scheduled appointments prepared to provide a urine sample. Failure to provide a sample may result in withdrawal of treatment using controlled substances and possibly discharge from The Nurse's Office.
10. 1. I understand that failing to report for a random pill count in the same business day that I was contacted is a direct violation of this agreement and subject to discharge from The Nurse's Office. I also agree to update all my contact information as it changes especially phone numbers and mailing address.
11. I agree to comply with my physicians' request for additional imaging studies, lab tests, diagnostic procedures (with separate informed consent), and referrals to additional specialists as recommended by my physician.
12. I understand that The Nurse's Office is a specialty consulting practice. The Nurse's Office staff will communicate with my Primary Care Provider, Specialists, Pharmacists, Therapists, Employer, and Family to assist in determining the best course for continued treatment for chronic pain. My care may be transferred back to my Primary Care Provider for continued prescriptions of controlled substances once my medical regimen has been optimized.
13. All my controlled substance prescriptions will be filled at the same pharmacy. Should I choose to change pharmacies, I will notify The Nurse's Office immediately.
14. It is recommended that patients prescribed medications by any of the providers at The Nurse's Office not drive while taking these medications. Many of the prescribed medications can cause impairment and may lead to a DUI or at fault accident.
15. Early refills are not provided. Medications may be prescribed at office appointments only. The Nurse's Office will not prescribe any medication after hours or on weekends. The Nurse's Office will not prescribe replacement medications should they become misplaced, stolen, or destroyed. No controlled substance prescriptions will be called in to your pharmacy at any time.
16. While being prescribed Narcotics from The Nurse's Office, I agree to NOT drink alcohol in excess. When submitting a Urine Drug Screen, if my alcohol levels are considered HIGH I understand that I may be discharged from the practice.
17. In the event a Prior Authorization is required for your prescription, you agree to NOT take the override (2-week supply). If you do so you understand that NO additional medication will be prescribed until your next scheduled appointment at The Nurse's Office.

Consequences for not following the treatment agreement are as follows:

I understand that any violation of this agreement may pose a health risk to myself and others and may result in a discontinuation of treatment with controlled substances if deemed medically prudent. Violation of this agreement may result in dismissal from the care of The Nurse's Office as well as reporting any illegal activities to appropriate law enforcement agencies. All patients who demonstrate difficulties managing their controlled substance medications will be referred to an Addiction Psychiatrist and/or a Clinical Psychologist or Counselor for further evaluation.

I have read this document, understand it, have had all questions regarding risks and conditions of the agreement answered satisfactorily, and I agree to all its elements.

Patient Signature:_____Date _____

This authorization contains the core elements outlined in the Health Insurance Protection Act (HIPAA). A property/casualty insurer is submitting this authorization.

Patient's Name: _____ Social Security Number: _____
Date of Birth: _____ Address: _____

1. I authorize the use or disclosure of the above-named individual's health information as described below for the purposes of handling their medical care.

2. The following individuals or organizations are authorized to make the disclosure: all persons with knowledge of my medical history.

3. The following persons or class of persons may receive disclosure or protected health information about the above-named person:

The Nurse's Office Primary Care and Walk-In Center, LLC
179 Linwood Ave
Colchester, CT 06415
P- (860) 603-3541 F: (860) 603-3544

The type of information to be disclosed includes: **(Please initial ALL the items below authorizing the release of these medical records, if such records exist)**

_____ All medical records (all information) Clinician office chart notes
_____ All hospital records (including nursing records and progress reports)
_____ Medical records needed for continuity of care
_____ Transcribed medical records
_____ Dental Records
_____ Most recent history
_____ Laboratory reports
_____ Emergency and urgent care records
_____ Pathology reports
_____ billing statements
_____ Diagnostic imaging reports
_____ Other:

5. _____ By initialing this area I understand that the information in my health records may include information relating to sexually transmitted disease Acquired Immune Deficiency Syndrome (AIDS), or Human Immune Deficiency Virus (HIV). It also may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

6. I also understand that I can revoke this authorization at any time by notifying The Nurse's Office, in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

7. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations the information described above may be re-disclosed and no longer protected by these regulations.

_____ _____
Signature of patient or authorized Legal Guardian, Date
Health Care Agent or other authorized Personal Representative

SOAPP-R

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please Include any additional Information Below: