MASSACHUSETTS GENERAL HOSPITAL
ANESTHESIA, CRITICAL CARE AND PAIN MEDICINE

Pain Management Center

Evaluation Request Form

Please fax **this form along with the last two visit notes** within the past six months to 617-726-3441. Our office responds to all referral inquiries within 48 hours of receipt. We sincerely appreciate your interest in our center.

General Information

Patient's name: _____

Address: _____

Home phone: _____ **Date of birth:** _____ / _____ / _____

Referring Physician: _____

Address: _____

_____

Phone: _____ **Fax:** _____

Primary Care Physician (if different from referring physician): _____

Phone: _____ **Fax**: _____

Is this a Worker's Compensation claim? Yes: _____ **No:** _____

Request Information

1. Chief complaint/diagnosis: _____
   Duration of symptoms: _____
2. Has the patient been seen by any other Pain Clinic? If so, please specify name of clinic:
   _____
3. What is your expectation from this evaluation?
   _____
4. Reason for request (please check one):
   - ○ Multidisciplinary evaluation
   - ○ Evaluation for an injection
   - ○ Medication Recommendations

Please fill in: As part of our comprehensive evaluation, we offer interventional options. We also provide an opinion or regimen for opioid management, if appropriate. However, we are unable to assume the responsibility for longitudinal prescribing or for short-term weaning of medications.

***Please verify who will assume prescribing (if it is necessary):** _____

- ○ Other (please specify): _____

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Consultation Services for Patients Receiving Chronic Opioid Therapy

Please note: In order to complete a meaningful consultation for both you and your patient, we REQUIRE that a completed copy of this form is returned with your request for any consultation regarding chronic opioid therapy.

We aim to assist patients and their providers in understanding how and when to use opioids for the long-term treatment of chronic pain.

We are frequently asked to assist with chronic opioid therapy. Because there are so many providers requesting our consultative services, we cannot assume primary prescribing responsibility for this therapy. Nonetheless, we are here to help you. Please help us understand how we can best assist you in the care of your patient by directing our attention to one of the following areas:

☐ **WHAT IS THE BEST OPIOID TO USE?**
Is this the best drug(s) for my patient? Please assess the drug/drug combination that this patient is receiving and help me to optimize.

☐ **SHOULD I START OPIOIDS AT ALL?**
I have not yet started chronic opioid therapy. Is chronic opioid therapy appropriate for my patient

☐ **SHOULD I CONTINUE OPOIDS?**
I have already started chronic opioid therapy and I am uncertain that I should continue this therapy. Please assess this patient and provide feedback about use of opioids in treating her/his ongoing pain.

☐ **HOW CAN I WEAN THE OPIOID?**
I have already started chronic opioid therapy and I am uncertain if I should continue this therapy. Please assess this patient and provide feedback about use of opioids in treating her/his ongoing pain.

☐ **HOW CAN I IMPROVE ADHERENCE AND OUTCOME?**
I am starting a patient on opioids or already have a patient with possible risk factors.
What are the specific steps that I can take to better insure adherence to the prescribed regimen?
How can I maximize the likehood that the patient will achieve adequate gains with respect to pain relief and improved function?

☐ **I THINK MY PATIENT IS ADDICTED TO OPIOIDS. WHAT SHOULD I DO?**
I already have started chronic opioid therapy and I am concerned that my patient is showing signs of addiction. How should I proceed?

Thank you for your referral. We will make every effort to directly assess your specific questions during the consultation and return our suggestions to you promptly. Please do not hesitate to call the consultant in our center directly, if you have additional questions after your patient has been evaluated.

Name of provider requesting consultation (please print):

_____