Lowell General Hospital

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Dear New Pain Management Patient,

Welcome to the Lowell General Hospital Pain Management Center. Please take time to review and complete the enclosed paperwork prior to your upcoming appointment. Accurate information on these forms is extremely important, so please take the time to complete **ALL** sections. Incomplete information may require us to re-schedule your initial appointment.

It is important for you to call our Pre-Registration Department and register for you upcoming Pain Center appointment. You may reach Pre-Registration at 978-937-6429. Please have your insurance card, auto accident or workman's compensation information ready before calling. If this is a result of an automobile accident or workman's comp injury, the registration department will ask for the date of injury, insurance company, phone and fax numbers, claim number and adjuster's name.

Please remember, if your insurance requires an insurance referral to the Lowell General Hospital Pain Management Center, this must be generated by your primary care physician and be in place prior to your appointment.

All co-payments are due at the time of service.

Finally, we ask that you arrive 20 minutes earlier than your appointment time so that we may have time to process this paperwork.

We look forward to assisting you with your healthcare needs.

Thank you,

Joanne Dusablon RN MSN

Joanne Dusablon, RN, MSN
Clinical Nurse Manager
Pain Management Center
2 Hospital Drive, Lowell, MA 01852
978-937-6460

Lowell General Hospital

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Pain Management Pain Questionnaire (Page 1 of 2)

Name:_____ Date:_____

Please complete the following information. **Incomplete information may delay your plan of care and treatment**.

Chief Complaint: Please briefly state the main reason you are coming to the Pain Clinic. For example: low back pain

_____

Is this pain constant or intermittent? ☐ Constant ☐ Intermittent

If your pain is intermittent, is there a time of WORSE BETTER

day when your pain is worse or better? _____AM/PM _____AM/PM

Are there activities that make your pain worse? For example: walking, stair climbing, sitting etc._____

_____

What makes your pain better? _____

Diagnostic Tests and Treatment:

Please give date of service and location of any diagnostic test you have had for this condition:

_____MRI _____CT Scan _____EMG _____Other

If testing done outside of the LGH system, please have test **report** faxed to the Pain Center – (978) 937-6842.

(We will not require the actual films or discs)

Please list pain treatments you have received –giving start date, length of therapy and if treatment was helpful.

Type:	Date of Service:	Length of therapy:	Helpful: Yes or No
Acupuncture:	_____	_____	_____
Chiropractor:	_____	_____	_____
Home Exercise:	_____	_____	_____
Massage:	_____	_____	_____
Physical/Aquatic Therapy:	_____	_____	_____
Steroid Injections:	_____	_____	_____
Surgery:	_____	_____	_____

Have you been seen by another Pain Management Service or Physician: Yes / No

Name of practitioner or practice: _____ Date of service: _____

Please obtain these records and have them faxed to the LGH Pain Center prior to initial appointment (978)937-6842

(turn over to page 2)

Medications:	Dose:	Date of Use:	Length of therapy	Helpful: Yes or No
Anti-Inflammatories or NSAIDS				
Ibuprofen (Advil)	_____	_____	_____	_____
Celecoxib (Celebrex)	_____	_____	_____	_____
Diclofenac (Voltaren/Zorvolex)	_____	_____	_____	_____
Etodolac (Lodine)	_____	_____	_____	_____
Meloxicam (Mobic/Vivlodex)	_____	_____	_____	_____
Nabumetone (Relafen)	_____	_____	_____	_____
Naprosyn (Naproxen/Aleve)	_____	_____	_____	_____
Neuropathic Pain Medications:				
Amitriptyline (Elavil)	_____	_____	_____	_____
Duloxetine (Cymbalta)	_____	_____	_____	_____
Nortriptyline (Pamelor)	_____	_____	_____	_____
Neurontin (Gabapentin)	_____	_____	_____	_____
Pregabalin (Lyrica)	_____	_____	_____	_____
Muscle Relaxants:				
Baclofen (Lioresal)	_____	_____	_____	_____
Carisoprodol (Soma)	_____	_____	_____	_____
Cyclobenzaprine (Flexeril)	_____	_____	_____	_____
Metaxalone (Skelaxin)	_____	_____	_____	_____
Methocarbamol (Robaxin)	_____	_____	_____	_____
Tizanidine (Zanaflex)	_____	_____	_____	_____
Narcotics :				
Buprenorhine (Belbuca/Butrans)	_____	_____	_____	_____
Hydrocodone (Vicodin)	_____	_____	_____	_____
Hydrocodone ER (Hysingla)	_____	_____	_____	_____
Hydromorphone (Dilaudid)	_____	_____	_____	_____
Fentanyl patch	_____	_____	_____	_____
Methadone	_____	_____	_____	_____
Morphine	_____	_____	_____	_____
Morphine ER (MS Contin)	_____	_____	_____	_____
Oxycodone	_____	_____	_____	_____
Oxycodone ER (OxyContin)	_____	_____	_____	_____
Oxycodone ER (Xtampza)	_____	_____	_____	_____
Tylenol with Codeine	_____	_____	_____	_____
Tramadol (Ultram)	_____	_____	_____	_____

If you do not already have a written medication list, please fill out information below. Include all prescribed, over the counter and herbal medications you are presently taking.
Also, please bring your prescription drug plan card with you.

NAME LABEL

NAME OF PRESCRIPTION DRUG PLAN:

ID#: **CUSTOMER SERVICE PHONE NUMBER:**

ALLERGIES:

MEDICATION AND DOSE	REASON FOR TAKING	FREQUENCY TAKEN

LOWELL GENERAL HOSPITAL INSURANCE FORM

PATIENTS NAME:_____
(FIRST (M.I.) (LAST)

DATE OF BIRTH:_____/_____/_____ CELL PHONE NUMBER_____

Please sign the following statement:

I certify that this visit is not an active work related injury, an auto accident or a pending lawsuit: I am aware my health insurance will be billed.

Signature: _____

TO BE COMPLETED *ONLY* IF THIS IS AN ACTIVE WORKERS COMP. INJURY, AUTO CLAIM OR A LEGAL CASE

Is injury Work Related**? Y / N** Auto Accident**? Y /** N Lawsuit Pending**? Y /** N Currently Working**? Y / N**

We need the following information about your accident/injury in order to process a claim for services.

IF THIS FORM IS NOT COMPLETED -YOUR HEALTH CARE INSURANCE OR YOU WILL BE BILLED FOR ALL CHARGES.* * Without this information we won't know who to bill or where to send the bill

INSURANCE COMPANY:_____Date of Injury/Accident___/___/___

INSURANCE ADDRESS:_____
(STREET) (CITY) (STATE) (ZIP)

INSURANCE TELEPHONE #_____FAX #_____

INSURED'S EMPLOYER:_____TEL #_____

EMPLOYER ADDRESS:_____
(STREET) (CITY) (STATE) (ZIP)

CLAIM #_____GROUP NAME/NUMBER_____
(CANNOT PROCESS WITHOUT NUMBER!)

***ATTORNEY NAME:_____TELEPHONE NUMBER_____**

ADDRESS_____
(STREET) (CITY) (STATE) (ZIP)

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS:***PLEASE COMPLETE***

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN THE PLACE OF THE ORIGINAL.

I HEREBY AUTHORIZE DR. HENKLE & LOWELL GENERAL HOSPITAL TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED BY HIS/HER ORDER, I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO DR. HENKLE & LOWELL GENERAL HOSPITAL.
THIS AUTHORIZATION MAY BE REVOKED BY EITHER ME OR MY INSURANCE COMPANY AT ANY TIME IN WRITING.

DATE:_____SIGNATURE:_____ _____
PATIENT, PARENT, OR GUARDIAN RELATIONSHIP

LGHINSURANCEFORM/ (shared folder)