



Pain Management Provider Report

Date: _____ Date of Last Visit: _____

Client: _____ Provider: _____

Facility Name: _____

Phone Number: _____ Fax Number: _____

The individual listed above is a Healthcare Professional being monitored by Peer Assistance Services, Inc. The program requires clinical information as part the individual’s assessment process and his/her rehabilitation and monitoring plan.

If the client’s medical condition requires the use of mood/mind-altering medications:

- The client must see the Pain Management Provider on a monthly basis for on-going evaluation.
- The Pain Management Provider must submit an initial Pain Management Plan to the clients Case Manager. Any changes in the Pain Management Plan must also be submitted to the Case Manager.
- The Pain Management Provider must also submit a monthly Pain Management Provider Report to the Case Manager.

1) What prescriptions/controlled medications are you currently prescribing for this individual?

<u>Medication Name</u>	<u>Dosage</u>	<u>Frequency</u>

2) What is the diagnosis that requires treatment with these medications? _____

3) What other treatments, both pharmacological and non-pharmacological, have been attempted? _____

4) What were the outcomes of these treatments? _____

Mail or Fax Original To:

Metro Denver, Northern and Southern:
Peer Assistance Services, Inc.
2170 S. Parker Road, Suite 229
Denver, CO 80231
Phone: 303.369.0039 or 866.369.0039
Fax: 720.213.1007

Western Slope Clients Only:
Peer Assistance Services, Inc.
200 Grand Avenue, Suite 260
Grand Junction, CO 81501
Phone: 970.986.4360
Fax: 970.241.9094



Pain Management Provider Report

Continued

Client: _____

5) Is treatment with these medications the only effective treatment for the individual's condition? (If yes, please explain) _____

6) How long do you anticipate that the individual will need to use this medication? _____

7) What are your recommendations to the individual for handling break-through pain? _____

8) Is the individual complying with the Pain Management Plan? (If no, please explain) _____

9) Is there any evidence of prescription/controlled medication abuse? Has the client's history of controlled substance prescriptions been reviewed in the Prescription Drug Monitoring Program (PDMP)? Please explain. _____

10) Are current prescription medications interfering in any way with the individual's ability to practice with reasonable skill and safety? _____

11) Has the individual informed you that he/she has a substance abuse disorder or a past history of problems associated with the use of prescription/controlled medications? _____

12) Has the individual presented you with a copy of PAS's Chronic Pain Management Client Agreement? _____

Additional Comments: _____

Pain Management Provider Signature: _____

Date: _____

Mail or Fax Original To:

Metro Denver, Northern and Southern:
Peer Assistance Services, Inc.
2170 S. Parker Road, Suite 229
Denver, CO 80231
Phone: 303.369.0039 or 866.369.0039
Fax: 720.213.1007

Western Slope Clients Only:
Peer Assistance Services, Inc.
200 Grand Avenue, Suite 260
Grand Junction, CO 81501
Phone: 970.986.4360
Fax: 970.241.9094