Pain Care

Pain Care Questionnaire
Pain Service Outcome Survey Form
Pain Services Contract for Care

The Chambersburg Hospital
Chambersburg, PA

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Distributed by the City of Hope Pain Resource Center 1995

CHAMBERSBURG HOSPITAL

PAIN SERVICE

OUTCOME SURVEY FORM

1. What is your pain score (0-10) :
   at rest _____?
   with gentle movement _____?
   with exertion _____?

2. What is an acceptable pain score for you: _____
   (refer to acceptable score goal on original assessment form)

3. Your present activity compared to before pain service therapy is:

   □ No change (0)
   □ 25% return to normal lifestyle (1)
   □ 50% return to normal lifestyle (2)
   □ 75% return to normal lifestyle (3)
   □ 100% return to normal lifestyle (4)

4. What therapies are you currently using to lower your pain level?

   □ None
   □ OPIOIDS
   □ NSIADS
   □ Antidepressants
   □ Axiolytics
   □ Other Meds:

   _____
   _____

   □ Heat
   □ Ice
   □ Exercise : _____
   □ TENS
   □ PT/OT
   □ Guided Imagery
   □ Relaxation
   □ Massage

□ Other:

_____

_____

_____

5. Do you have any unanswered questions about your pain and/or treatment?

□ No □ Yes (What)

_____
_____
_____

6. Are there areas where the pain service has not met your pain needs?

□ No □ Yes (Where)

_____
_____
_____

7. Would you choose not to return (or send a family member) to the pain service should the need arise?

□ No □ Yes (Why)

_____
_____
_____

The Chambersburg Hospital
Pain Care Questionnaire

We are very interested in your comments regarding ANY PAIN and pain relief that you may have experienced during your RECENT care at The Chambersburg Hospital. Do you have a few moments to help us by answering a few questions? Thank You!

1.DID YOU EXPERIENCE PAIN, DURING YOUR STAY? YES ( ) NO ( )
2. DID YOU EXPERIENCE UNRELIEVED PAIN ? YES ( ) NO ( )
A. IF YES, HOW OFTEN?
Constant ( ) Several Times ( ) 1-2 Times Daily ( ) 1-2 times/Hospital Stay ( )

[0=No Pain ----------10=Worse Pain Imaginable]
3. PLEASE SCORE YOUR HIGHEST PAIN LEVEL: _____
4. PLEASE SCORE YOUR LOWEST PAIN LEVEL: _____

5. DID YOU TELL A NURSE OR DOCTOR THAT YOU HAD UNRELIEVED PAIN?
YES ( ) NO ( )
A. IF YES, DID YOU ASK FOR PAIN RELIEF? YES ( ) NO ( )
B. IF NO, WHY NOT?
_____

6. DID YOU RECEIVE PAIN RELIEF? YES ( ) NO ( )
A. IF YES, WHAT WAS USED TO RELIEVE YOUR PAIN?
_____

7. IF YOU REVEIVED PAIN MEDICATION, PLEASE ANSWER THE FOLLOWING:
A. DID YOU EXPERIENCE DROWSINESS?
Severe _____ (3) =Difficult for me to wake up
Moderate _____ (2) = slept most of the time, but easy to wake up
Mild _____(1) = "Cat naps" between visitors
None _____(0)

B.DID YOU EXPERIENCE NAUSEA OR VOMITITNG?
Severe _____(3)
Moderate _____(2)
Mild _____(1)
None _____(0)

C. DID YOU EXPERIENCE ITCHING, THAT IS UNUSUAL FOR YOU?
Severe _____(3) = Unbearable
Moderate _____(2) = Controlled by extra medication
Mild _____(1) = Tolerable or Occasional
None _____(0)

8. OVERALL, I WAS SATISFIED BY THE WAY MY PAIN WAS MANAGED:
Agree ( ) Disagree ( ) Don't Know ( )
Comments:
_____
_____

9. WITH REGARD TO MY PAIN MANAGEMEN, I WISH THAT:
_____

PAIN QUESTIONNAIRE

(Clinical Notes/Chart Review)

Date: _____

Admission Date: _____

Discharge Date: _____

MR# _____

Clinical Area: _____

DIAGNOSIS: _____

ADMITTING PHYSICIAN: _____

TYPE OF SURGERY: _____ DATE: _____

N/A ( )

SUGEON: _____

ADDITIONAL COMMENTS (optional):

_____

_____

_____

_____

THE CHAMBERSBURG HOSPITAL

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CHAMBERSBURG PAIN SERVICES
CONTRACT FOR CARE

I. The goals of treatment are: (1) reduced Pain; (2) improvement in activities of daily living; (3) increased ability in self-management of remaining pain; (4) decreased reliance on the Health Care System.

II. Inability of the treatment plan established by the Pain Care team to meet these goals will be considered a failure of treatment. An integral part of the treatment program is the responsibilities as stated below.

III. Failure of the treatment program will be managed by: (1) tapering of all pain-related medication; (2) patient discharge from the Pains Service Program; and (3) return to primary care or original referring physician.

1. All pain medications will be prescribed by the Chambersburg Pain physicians ONLY.

2. All medications prescribed in the pain treatment program, will be taken as directed by the Pain Service physicians.

3. The patient has the responsibility to comply with the Pain Service physician's orders, treatment plan and required appointments. The Pain Service physician will be responsible for ordering patient medication, treatment options, and follow-up visits.

4. Opioid medications may be used along with other medications to provide maximal pain relief and minimal side effects. The Pain Service physician will prescribe these medications in accordance with his/her medical judgment, and as appropriate for the individual patient. It may require either the decrease or increase of doses as necessary to achieve this balance.

5. A specific number of rescue doses may be provided to assist the patient with possible accelerations of severe pain.

6. Patients will be responsible for their prescriptions. NO REPLACEMENT PRESCRIPTIONS will be provided for lost medication, lost prescription, or other reasons for changes in prescribed supply.

7. Patients will keep scheduled appointments with all physicians, therapist, and other prescribed treatments. Any planned absences must be made in advance, preferably within 24 hours. Repeated absences judged by the Pain Care Team to

reflect the lack of patient responsibility will result in tapering of medication and discharge from the program.

8. Patients will not use emergency services as a rescue for severe pain. Management of severe pain at home will be encouraged. Repeated use of the emergency care unit or inability of the patient to develop self-management techniques for increased pain will result in tapering of medication and discharge from the program.

9. Frequent calls to the Pain Service will be viewed as an inability of the patient to self-manage pain and a failure of treatment.

10. Discovery of diversion or use of prescribed medication by anyone other than the patient under treatment will be immediately reported to the legal authorities.

11. Patients will be expected to arrange for payment in advance. The option of a modified payment scheduled may be arranged. Issues of reimbursement will NOT prevent patients from receiving care; however, they must show responsibility for this aspect of their treatment.

_____ _____

Patient Signature *Date*

_____ _____

Physician Signature *Date*