Peer Assistance Services

Pain Management Provider Report

Date: _____ **Month submitted for:** _____ **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 Pain Management Provider Report to the Case Manager at a frequency determined by the Case Manager.

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

Medication Name	Dosage	Frequency

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? _____

_____

_____

Reports may be submitted via:

Email: reports@peerassist.org

Fax: Last name A-L 720.213.1007
Last Name M-Z 720.213.0002

Mail: Peer Assistance Services
2170 S. Parker Road, Suite 229
Denver, CO 80231

In Person: Peer Assistance Services, Inc.
2170 S. Parker Road, Suite 229
Denver, CO 80231

or

Peer Assistance Services, Inc.
200 Grand Avenue, Suite 270
Grand Junction, CO 81501

Peer Assistance Services

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:** _____

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