



IEHP PAIN ASSESSMENT & TREATMENT PLAN

Patient Name: _____ DOB: _____

PER #: _____ Member ID #: _____

Diagnosis

Please provide diagnosis on record:

Pain Assessment

On a scale of 0 - 10, how would you assess the patient's current pain (0 = No pain, 10 Worst pain). Please circle one:

0 1 2 3 4 5 6 7 8 9 10 Comments: _____

On a scale of 0 - 10, what is the pain scale goal for this patient (By implementing treatment, how much do you feel you can decrease the patient's pain)? Please circle one:

0 1 2 3 4 5 6 7 8 9 10 Comments: _____

Is the patient experiencing any side effects from current pain reliever(s)?
(Please circle one): Yes or No. If yes, please explain:

Is the patient exhibiting any potential aberrant drug related behavior (e.g. early refills, frequent lost or stolen medications, history of abuse, other.)?
(Please circle one): Yes or No. If yes, please explain:

Current Analgesic Regimen

Drug Name	Strength (e.g. mg, gm, ml)	Frequency
1.		
2.		
3.		
4.		

Treatment Plan

Please check one:

Continue present regimen

Adjust dose of present regimen

Switch analgesic

Add/adjust concomitant therapy

Discontinue/taper off opioid therapy

Comments:

Requested Length of Authorization

Please check one:

1 month

3 months

6 months

Please provide reason for requests greater than 1 month:

Please sign and fax to IEHP (909)890-2058. We appreciate your prompt response.

Physician Name (Print): _____ Physician Signature: _____

Date: _____ Physician's Phone: _____