North Jersey Orthopaedic Specialists, P.A. – Pain Management Agreement

This agreement is in compliance with the New Jersey Drug Addiction and Treatment Reform Law. The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you. The long-term use of substances such as, opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives are controversial because of uncertainty regarding the extent to which they provide long-term benefits. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain. Because these drugs have potential for abuse or diversion, strict accountability is necessary. For this reason, the following policies are agreed by you, the patient, as consideration for and a condition of the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception.
2. All controlled substances must be obtained at the same pharmacy. Should the need arise to change pharmacies, our office must be informed.

   The **pharmacy** that you have selected is:

   Pharmacy name: _____ **Phone:** _____

3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacist or other professionals who provide your health care for purposes of maintaining accountability.
5. You may not share, sell, or otherwise permit others to have access to these medications.
6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.
8. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.
9. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
10. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.
11. Early refills will not be given.
12. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.
13. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
14. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by the physician or referral for further specialty assessment.
15. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on the weekends.
16. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.
17. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation).
18. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

Patient Signature: _____ **Date:** _____

Patient Name (Printed): _____ **Account #:** _____

(Revised 6/7/17)

North Jersey Orthopaedic Specialists, P.A.

PATIENT RECORD of DISCLOSURES

I wish to be contacted in the following manner (check all that apply):

____ **Home Telephone**

____ O.K. to leave a message with detailed information

____ Leave message with call-back number only

____ **Written Communication**

____ O.K. to mail to home address

____ O.K. to mail to my work/office address

____ O.K. to fax to number listed below:

_____

____ **Work Telephone**

____ O.K. to leave message with detailed information

____ Leave message with call-back number only

____ **Other**

_____

_____

Patient/Guardian Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

NORTH JERSEY ORTHOPAEDIC SPECIALISTS, P.A.

BONE AND JOINT SURGERY • SPORTS MEDICINE • PEDIATRIC ORTHOPEDICS • HAND SURGERY

PRIMARY CARE PROVIDERS / TREATING PHYSICIANS

Physician: _____ Phone: _____

Condition being treated: _____

Physician: _____ Phone: _____

Condition being treated: _____

Physician: _____ Phone: _____

Condition being treated: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Phone:_____

Location: _____

EMAIL

Please indicate your **EMAIL ADDRESS** if you would like access to our **MEDICAL PORTAL**:

_____@_____. _____

North Jersey Orthopaedic Specialists, P.A.

RECEIPT of HIPAA NOTICE OF PRIVACY PRACTICES

I have received a copy of the Health Insurance Portability and Accountability Act (HIPAA) NOTICE of PRIVACY PRACTICES.

Patient Name: _____

Patient or Guardian Signature: _____

Date: _____

North Jersey Orthopaedic Specialists, PA

Initial Evaluation/Consultation Form

Date:
Patient ID#:

Please complete through the dashed line on this page.

Name: _____ Age: _____ Height: _____ Weight: _____

Referred by: _____

Why are you here? _____

_____

Primary language (if other than English): _____ Name of translator: _____

Medical History

Allergies: _____ Please List: _____

Medications and Doses: _____

_____

Review of Systems (2,10,10): List problems with the following areas (check ☐ if normal).

- ☐ Recent weight loss: _____ Change in appetite: _____ Fatigue: _____ Sweats/Chills: _____
- ☐ Eyes or vision: _____
- ☐ Ears, nose or throat: _____
- ☐ Heart/Circulation (blood clots, high blood pressure): _____
- ☐ Respiratory (asthma, shortness of breath): _____
- ☐ Gastrointestinal (ulcers, gastritis, constipation, diarrhea): _____
- ☐ Genitourinary: _____
- ☐ Musculoskeletal (fractures, arthritis, osteoporosis): _____
- ☐ Skin (rashes): _____
- ☐ Neurological: _____
- ☐ Psychiatric (depression): _____
- ☐ Endocrine (diabetes): _____
- ☐ Hematologic/ lymphatic (bleeding tendency, anemia): _____
- ☐ Allergy/Immunologic (drug allergies, latex): _____

Past Medical History (1,3,3)

List all previous illnesses/hospitalizations/surgeries and dates: _____

_____

_____

Family History- List parents and siblings with ages and state of health: _____

_____

_____

Social History: Marital Status: _____ Occupation: _____

Children: _____

Do you smoke? _____ How much? _____ Do you drink? _____ How much? _____

Hobbies/Sports: _____

STOP!

History of present Illness (4,4,4):

1st complaint: _____ 2nd complaint: _____

Location: _____

Quality (sharp, dull, burning) _____

Severity (scale of 0 - 10): _____

Duration: hours days months years

Timing: AM / day / night _____

Context: work / recreation _____

Modifying factors: _____

Position / walk / steps / vasalva _____

Associated symptoms _____

Swelling / warmth / discoloration _____

Locking / popping / instability _____

Weakness / numbness / bowel or bladder _____