BARNES-JEWISH West County Hospital
BJC HealthCare

Thank you for scheduling an appointment with the Barnes-Jewish West County Hospital Washington University Physicians Pain Management Center, located in **Medical Office Building 4, 1044 N. Mason Road, Suite L30 Creve Coeur, MO 63141.**

We have enclosed a *New Patient Questionnaire* for you to complete PRIOR to coming to your first appointment. We have also enclosed a Communication Form (PHI); which tells us who we may communicate with regarding your Personal Health Information. Please bring these forms completed along with your insurance cards to your initial appointment.

The Pain Management Center is a facility-based practice at Barnes-Jewish West County Hospital. Since we are a facility-based practice, there are TWO (2) SEPARATE BILLS incurred at each visit. The PROFESSIONAL CHARGES are from Washington University Physicians. The FACILITY CHARGES are from Barnes-Jewish West County Hospital.

Please note that some insurance companies require an authorization. Without receiving this referral PRIOR to your appointment, we reserve the right to reschedule your appointment. The referral must state the treating Physician by name and the facility, Barnes-Jewish West County Hospital.

Please note prescriptions ARE NOT written at the first office visit.

If services are to be covered under **Worker's Compensation Benefits**, we require that you complete a detailed form to include the address to bill, a contact name, phone number, and a claim number. This information must be completed BEFORE you are seen.

If you DO NOT have insurance coverage, you will be considered **Self-Pay.** At that time of your visit, you will be required to complete a **Patient Responsibility Form.** Partial payments for services for the Washington University Physicians, is required at the time of service. Financial assistance is available through Washington University School of Medicine and Barnes-Jewish West County Hospital. Co-payments are expected at the time of services. We accept cash and all major credit cards.

NEW PATIENT CHECKLIST (Bring to your FIRST appointment)

- _ Completed New Patient Questionnaire
- _ Insurance card(s) & Photo ID
- _ Referral (if required) or completed Work Comp Form (if applicable)
- _ Co-payment
- _ Medication List (if applicable)

We look forward to meeting you.
Your appointment date and time is: _____

The Pain Management Center

Created by: LHanks
Revised: 2.20.2020

BARNES-JEWISH West County Hospital
BJC HealthCare

BJWC Hospital
Washington University Physicians
Pain Management Center

Medical Office Building 4
1044 North Mason Road, Suite L30
Creve Coeur, MO 63141
Office Phone: 314-996-8631
Fax: 314-996-8742

(Facility Charges)

BILLING AND FINANCIAL ASSISTANCE

Please call **314.362.8400** or toll-free **855.362.8400**

with any inquiries about your bill.

(Physician Charges)

WASHINGTON UNIVERSITY PATIENT BILLING

Please call the Patient Services line at

(314) 273-0500 or toll free **(800) 862-9980**

with any inquiries about your bill.

Created by: LHanks
Revised: 2.20.2020

BARNES-JEWISH West County Hospital
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PATIENT IDENTIFICATION LABEL

Washington University Physicians
Pain Management Center

To Our Patients,

The Pain Management Center is a facility based practice located on the campus of Barnes-Jewish West County Hospital. What this means to you is that even though the office is located in a physician office building, The Pain Management Center is actually a department of Barnes-Jewish West County Hospital. As a hospital department, we guarantee that you will receive the same high level of care and commitment to patient safety as when you receive services in our other outpatient departments such as, Ambulatory Surgery, Radiology, or the Emergency Department.

As separate providers, the physicians and the hospital bill separately for their respective services. As a patient who will be receiving pain management services in the Pain Management Center, you will be responsible for a co-insurance liability for the outpatient hospital services that you receive, as well as those required by your insurance plan for the physician services.

Barnes-Jewish West County Hospital will bill for the outpatient care, including fluoroscopic imaging, supplies and medications used during the procedure and clinical care (nursing and radiology tech) that you receive while a patient at the Pain Management Center.

You will also be responsible for the physician charges concerning your care. If your insurance plan includes physician co-pay, this is expected at the time of the visit. If you plan includes a co-insurance amount and you have not met the deductible for the year, you will receive an additional bill from Washington University Physician Services for those charges.

If you have any questions regarding the information in this letter, we will be pleased to answer any question you may have.

My signature indicates that I have read and understand that the Pain Management Center is an outpatient facility based practice of BJWCH.

_____ _____

Patient Signature Date

Created by: LHanks
Revised: 2.20.2020

BARNES-JEWISH West County Hospital
BJC HealthCare

PATIENT IDENTIFICATION LABEL

Pain Management Center
Patient Communication Form (Please Print)

DATE: _____

Would you like to sign up for the Washington University Follow My Health Patient Portal? YES☐or NO☐
If YES, please provide an email address for communication:

_____

My patient health information may be discussed with the following family members or friends:

Name: _____ Relationship _____ Phone: _____

Name: _____ Relationship _____ Phone: _____

Name: _____ Relationship _____ Phone: _____

Messages concerning medication refills, appointments, and responses to patient calls can be left at the following phone number(s):

Home: _____ Cell: _____

Work: _____ Other: _____

Can you receive text messages on your cell? YES☐or NO☐

Please add Emergency Name and Number where we may leave a message to contact you:

Name: _____ Relationship _____ Phone: _____

Name: _____ Relationship _____ Phone: _____

The following person(s) may pick up my prescriptions at the office:

Name: _____ Relationship _____ Phone: _____

Name: _____ Relationship _____ Phone: _____

Name: _____ Relationship _____ Phone: _____

Preferred pharmacy name and phone number:

Pharmacy Name: _____ Phone: _____

Signature _____ Printed Name _____ Date: _____

Created by: LHanks
Revised: 2.20.2020

BARNES-JEWISH West County Hospital
BJC HealthCare

PATIENT IDENTIFICATION LABEL

Pain Management Center
Blood Thinner Questionnaire

Dear Patient,

Do you take any of the following medications below, frequently referred to as "Blood Thinners?"

☐ YES ☐ NO

If YES, please circle the medication you are taking.

☐ Aggrenox	☐ Eliquis	☐ Pletal
☐ Brilinta	☐ Jantoven (Warfarin)	☐ Pradaxa
☐ Coumadin (Warfarin)	☐ Lovenox	☐ Ticlid
☐ Effient	☐ Plavix	☐ Xarelto

Before any procedure or injection can be scheduled, the doctor who prescribes THIS medication MUST be contacted. Please provide the name and number of your doctor who prescribes the above medication.

Physician: _____ Phone: _____

The Pain Management nurse will contact your doctor to obtain permission for you to stop your medication for the appropriate length of time, prior to treatment. The nurse will then contact you to coordinate your treatment and confirm instructions regarding your "blood thinner."

REMINDER

Do not stop your blood thinner until you have been given specific instructions!!! Stopping any medication without your healthcare team's guidance may be harmful to your health.

Created by: LHanks
Revised: 2.20.2020

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PATIENT QUESTIONNAIRE

ADDRESSOGRAPH

Initial Office Visit

Date: _____

Patient Name: _____ **Date of Birth:** _____

Please complete the questionnaire as fully as possible to assist us with your evaluation and treatment. Please read each question carefully and answer to the best of your ability. This information is part of your medical record, and will not be released without your permission.

Briefly describe your pain: _____

_____

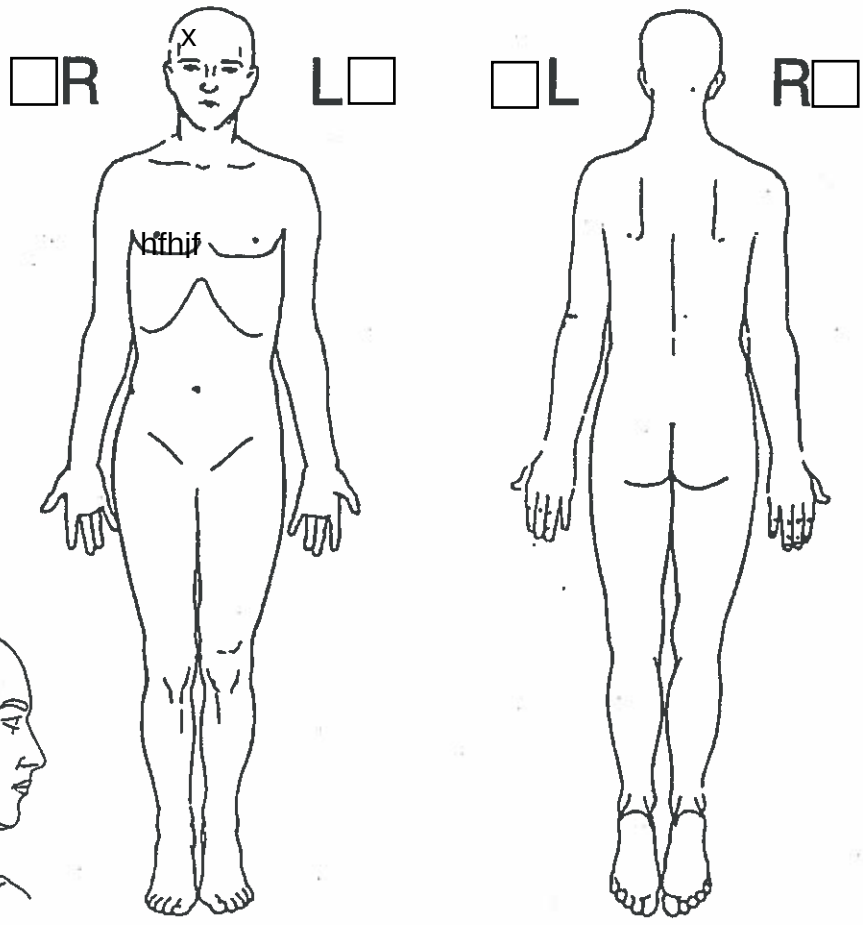
_____

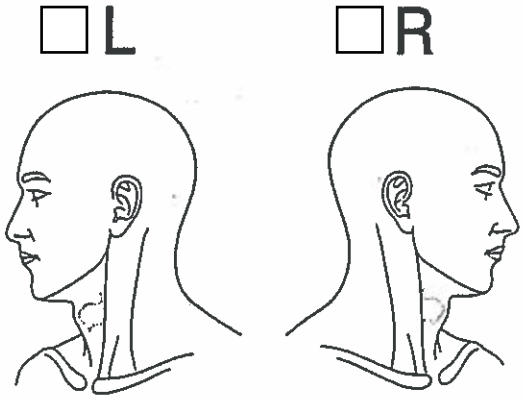
Where is Your Pain?

Using the symbols listed below, mark on the drawings the areas where you feel your pain. If you feel more than one sensation in the same area, mark over that area with additional symbols that apply. Show all affected areas.

Symbols

- - - - -	numbness
0000	pins and needles
xxxx	burning
////	stabbing
+++	aching
E	external (on or outside the body)
I	internal (inside the body)





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PATIENT QUESTIONNAIRE

ADDRESSOGRAPH

Patient Name: _____ Date of Birth: _____

How and when did your pain start? _____

_____

_____

Have there been any significant changes in the quality or intensity of your pain since it started? If yes, describe those changes:

_____

_____

Which word (or words) best describes the patterns of your pain?
☐ Continuous ☐ Comes and goes ☐ Brief/momentary

Is your pain usually WORSE during a certain time of day? ☐ Yes ☐ No
If yes, when? ☐ Morning ☐ Midday ☐ Evening ☐ Night

Is your pain usually BETTER during a certain time of day? ☐ Yes ☐ No
If yes, when? ☐ Morning ☐ Midday ☐ Evening ☐ Night

Please use the Following Chart to Complete Pain Scale Questions:

ADL's = Activities of Daily Living (i.e. walking, house chores)

0	1	2	3	4	5	6	7	8	9	10
Does not interfere with ADL's		Mildly interferes with ADL's		Somewhat interferes with ADL's		Partially interferes with ADL's		Greatly interferes with ADL's		Completely interferes with ADL's
No Pain		Mild Pain		Moderate Pain		Severe Pain		Very Severe Pain		Worst Possible Pain

Choose the number which best describes the intensity of your pain by placing an "X" on the line.

0 = NO PAIN 10 = WORST PAIN IMAGINABLE

	0	1	2	3	4	5	6	7	8	9	10
Your pain right now											
Your pain at its worst											
Your pain at its least											
The worst toothache you ever had											
The worst headache you ever had											
The worst stomach ache you ever had..											
Labor pain											

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PATIENT QUESTIONNAIRE

ADDRESSOGRAPH

What makes your pain "Better", "Worse", or "No Effect"? Please check the appropriate boxes below:

	Better	Worse	No Effect		Better	Worse	No Effect
Heat	☐	☐	☐	Lying down/sleeping	☐	☐	☐
Cold	☐	☐	☐	Stress/worry	☐	☐	☐
Bath/shower	☐	☐	☐	Exercise/activity	☐	☐	☐
Walking	☐	☐	☐	Sexual activity	☐	☐	☐
Sitting	☐	☐	☐	Reading/TV	☐	☐	☐

Do you have any of the following symptoms with your pain?

☐ vomiting	☐ sweating	☐ noise sensitivity	☐ nausea	☐ blurred vision
☐ light sensitivity	☐ dizziness	☐ numbness/tingling	☐ irritability	☐ feeling faint
☐ rapid heart beat	☐ anxiety	☐ rapid breathing	☐ loud heart beat	☐ depression

List specific ways your life would be different if you had less pain or no pain: _____

_____

_____

Realistic goals or expectations from treatment at PMC: _____

_____

_____

What pain-related evaluations have you had?	**Date**	**Hospital**
X-rays		
Myelogram		
CAT Scan		
MRI		
Nerve and Muscle Tests		
Other_____		
Other_____		

Listed below are procedures commonly used in pain treatment. Please indicate those treatments you have had and whether or not they were helpful to you.

Procedure	**Date**	**Was it Helpful?**	**% Decrease in Pain**
☐ Surgery Related to Pain		☐ Yes ☐ No	0% _____ 100%
☐ Nerve Block		☐ Yes ☐ No	0% _____ 100%
☐ Steroid Injections		☐ Yes ☐ No	0% _____ 100%
☐ Physical Therapy		☐ Yes ☐ No	0% _____ 100%
☐ Psychological Counseling		☐ Yes ☐ No	0% _____ 100%
☐ Relaxation Training		☐ Yes ☐ No	0% _____ 100%
☐ Biofeedback		☐ Yes ☐ No	0% _____ 100%
☐ Chiropractic Treatment		☐ Yes ☐ No	0% _____ 100%
☐ Other_____		☐ Yes ☐ No	0% _____ 100%

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PATIENT QUESTIONNAIRE

ADDRESSOGRAPH

BACKGROUND INFORMATION

How is your sleeping? ☐ Good ☐ Fair ☐ Poor

Do you smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Do you use any illegal drugs? ☐ Yes ☐ No

If "Yes", please list: _____

Have you ever had a problem with drugs or alcohol? ☐ Yes ☐ No

What is your job? _____

Are you still working? ☐ Yes ☐ No If No, who ordered? _____

If you are no longer working, how long have you been off work? _____

Are you disabled? ☐ Yes ☐ No

Do you receive social security disability? ☐ Yes ☐ No

Educational Background (check all that apply and enter the number of years):
☐ GED ☐ High School_____years ☐ College/Technical School_____years
☐ Other: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Children: ☐ Yes ☐ No How many? _____ Ages: _____

Who lives with you? _____

If your pain is the result of injury, accident, or surgery, have there been any lawsuits? ☐ Yes ☐ No

If your injury is job related, is there a Worker's Compensation claim filed? ☐ Yes ☐ No

Do you currently retain an attorney? ☐ Yes ☐ No

Referring Physician: _____ Primary Physician: _____

Address: _____ Address: _____

_____ _____

Telephone #: _____ Telephone #: _____

Other Consulting Physicians:

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Telephone #: _____ Telephone #: _____

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PATIENT QUESTIONNAIRE

ADDRESSOGRAPH

Personal Health History

All information will be kept strictly confidential

Please check all conditions which you currently have.

Constitutional Symptoms
- ☐ Fever
- ☐ Fatigue

Eye
- ☐ Eye pain
- ☐ Blurred Vision
- ☐ Glaucoma
- ☐ Discharge
- ☐ Glasses
- ☐ Light sensitivity

Ears
- ☐ Discharge
- ☐ Pain
- ☐ Hearing/Difficulty/Aide

Nose
- ☐ Pain
- ☐ Discharge
- ☐ Congestion
- ☐ Bleeding
- ☐ Sinus Infection

Mouth
- ☐ Dentures
- ☐ Jaw/tooth pain
- ☐ Mouth sores

Throat
- ☐ Sore throat
- ☐ Hoarseness

Nutritional Assessment
- ☐ Weight loss/gain
- ☐ Poor appetite
- ☐ Nutritional supplement use

HT_____
WT _____

Cardiovascular
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Heart attack
- ☐ Abnormal heart rhythm
- ☐ Swelling of ankles
- ☐ Pacemaker/AICD
- ☐ Blood clot
- ☐ Use of blood thinners
- ☐ MVP

Respiratory
- ☐ Painful breathing
- ☐ Productive cough
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Shortness of breath
- ☐ TB
- ☐ Asthma

Gastrointestinal
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Hiatal hernia
- ☐ Nausea and vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Ulcers
- ☐ Liver, gallbladder problems, black, bloody stools

Genitourinary
- ☐ Painful urination
- ☐ Bladder infection
- ☐ Difficult urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Testicle problem
- ☐ Flank pain
- ☐ Sexually transmitted disease
- ☐ Nocturia
- ☐ Sexual dysfunction

Musculoskeletal
- ☐ Arthritis
- ☐ Bursitis
- ☐ Pain/numbness
  - ☐ Shoulder
  - ☐ Arms
  - ☐ Hands
  - ☐ Elbows
  - ☐ Neck
  - ☐ Hip
  - ☐ Legs
  - ☐ Knees
  - ☐ Feet
  - ☐ Tailbone
  - ☐ Back
- ☐ Poor posture
- ☐ Sciatica
- ☐ Spinal curvature
- ☐ Swollen joints
- ☐ Joint replacement
- ☐ Back surgery

Integumentary (skin or breast)
- ☐ Rash
- ☐ Itching
- ☐ Bruise easily
- ☐ Shingles
- ☐ Skin cancer

Neurological
- ☐ Headache
- ☐ Multiple sclerosis
- ☐ Seizures
- ☐ Head injury
- ☐ Stroke
- ☐ Tremors
- ☐ Weakness/numbness/tingling
- ☐ Dizziness
- ☐ Loss of coordination

Psychiatric
- ☐ Memory loss
- ☐ Alzheimer's
- ☐ Depression
- ☐ Anxiety
- ☐ Alcoholism
- ☐ Thoughts of suicide
- ☐ Irritability

Endocrine
- ☐ Sweats
- ☐ Thyroid disease
- ☐ Diabetes

Hematologic/Lymphatic
- ☐ Leukemia
- ☐ Bruising
- ☐ Bleeding disorder
- ☐ Swollen glands
- ☐ Hepatitis

Allergic/Immunologic
- ☐ Hay fever
- ☐ Allergies (other than drugs)
- ☐ AIDS/HIV
- ☐ Cancer _____

Women Only
- ☐ Congested breasts
- ☐ Cramps or backache
- ☐ Excess menstruation
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Painful menstruation
- ☐ Vaginal discharge
- ☐ Pain on intercourse

Family History

Mother: _____
_____
_____

Father: _____
_____
_____

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PATIENT QUESTIONNAIRE

ADDRESSOGRAPH

Other Medical Conditions / Surgeries in last 10 years:

Medical Conditions / Surgery	Date	Hospital

Have you ever had problems (such as anxiety, depression, or others) that were treated by a psychiatrist or psychologist, or for which you were hospitalized? ☐ Yes ☐ No If "Yes" what were the circumstances? _____

Do you presently feel depressed? ☐ Yes ☐ No

Medication Profile

ALL CURRENT MEDICATIONS

Date Started	Medication / Dose / Strength	Date Started	Medication / Dose / Strength

Nutritional Supplements (if any):

PREVIOUS PAIN MEDICATIONS

Date Started	Medication / Dose / Strength	Date D/C	Reason Discontinued

MEDICATION ALLERGIES

Medication	Reaction

Patient Signature:

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PATIENT QUESTIONNAIRE

ADDRESSOGRAPH

NURSING CAREPATH ASSESSMENT

BARRIERS TO LEARNING

☐ Anger ☐ Anxiety ☐ Cultural ☐ Denial ☐ Depression
☐ Hearing ☐ Language ☐ Literacy ☐ Pain ☐ Motivation
☐ Vision ☐ Socio-economic ☐ Other _____

ABUSE (AWARE) SUSPECTED:

☐ No ☐ Yes, intervention: _____

NURSING DIAGNOSIS:

☐ Uncontrolled pain due to chronic pain and other related conditions
☐ Controlled Pain with current treatment plan

NURSING PLAN OF CARE:

☐ Patient will verbalize understanding of the importance of treating pain with a multi-disciplinary approach
☐ Patient will state/demonstrate that pain is relieved, minimized or controlled.

RN Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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