TANNER PAIN MANAGEMENT CENTER
150 HENRY BURSON DRIVE, SUITE 110
CARROLLTON, GA 30117
770 812-5720 phone
770 812-5729 fax

Dear New Patient:

Your physician has referred you for a consultation to the Tanner Pain Management Center. Please read this letter carefully.

Enclosed is a map to the Tanner Pain Management Center. We are located on Henry Burson Drive in the 150 building behind Occupational Health/EAP. When you enter the building take the hallway to the right and we are in Suite 110.

You will also find a packet of patient information/history that must be completed in its entirety and brought with you to your consultation. If you need help completing this paperwork, please have someone to help you with it. If it is not completed when you arrive, your appointment will be rescheduled. Please review all agreements in your packet carefully. Any questions you have will be answered at your appointment.

Please bring photo identification (ex. driver's license), your insurance card(s) and your medications with you to every appointment. Failure to do so will delay your appointment.

Insurance copays, coinsurance, and deductibles are due and payable at each visit. Tanner Pain Management Center is an outpatient department of Tanner Medical Center. Please contact your insurance company prior to your consultation to determine what portion of your visit is your responsibility. Should you need assistance with your medical expenses, please ask about various payment assistance options.

If you are unable to make your appointment, please call at least 24 hours prior to your appointment. Chronic missed appointments will lead to dismissal from the center. **Please note, if you are more than 15 minutes late for your appointment, you will be asked to reschedule.**

Please be advised if you "Reschedule" your appointment more than twice we will not be able to schedule another appointment. Any "No show" appointments will not be rescheduled. The referring Physician will be notified.

We wish to provide you with the best service and care possible.
THANK YOU FOR YOU COOPERATION.

WELCOME TO TANNER PAIN MANAGEMENT CENTER!!!!

TANNER HEALTH SYSTEM

705 Dixie Street
Carrollton, GA 30117
770.812.9666

Driving Directions to 705 Dixie Street

From Atlanta:
Take I-20 west to Exit 24 (Highway 61). Turn LEFT onto Highway 61. Proceed approximately 12 miles southwest to Carrollton. You will stay on Highway 61, which becomes Bankhead Highway as you reach Carrollton, and finally becomes Newnan Street a few blocks before Dixie Street. Turn LEFT onto Dixie Street. Proceed 0.6 miles. Tanner Medical Center/ Carrollton is located on your RIGHT.

From Villa Rica:
Go south on Highway 61. Proceed approximately 12 miles southwest to Carrollton. You will stay on Highway 61, which becomes Bankhead Highway as you reach Carrollton, and finally becomes Newnan Street a few blocks before Dixie Street. Turn LEFT onto Dixie Street. Proceed 0.6 miles. Tanner Medical Center/Carrollton is located on your RIGHT.

From Highway 27 South:
(Bremen, Cedartown, Rome)
Take Highway 27 south from Bremen to Carrollton. Highway 27 is called North Park Street in Carrollton and then changes to South Park Street after it crosses Alabama Street. After crossing Alabama Street, proceed to the second traffic light, which is Clinic Avenue, and turn LEFT. The hospital will be on your LEFT. To enter the hospital through the main Dixie Street entrance, proceed on Clinic Avenue past the first parking area, past the side of the hospital, and turn LEFT into the second parking area.

From Highway 27 North:
(Columbus, LaGrange, Newnan)
Take Highway 27 north to Carrollton. After crossing the 166 Bypass interchange, stay in the right lane. Approximately 100 yards after crossing the 166 Bypass interchange, Highway 27 curves to the left. Follow the right lane straight ahead onto Dixie Street. Proceed 0.5 miles north on Dixie Street. Tanner Medical Center/Carrollton is located on your LEFT.

Tanner Medical Center, Inc.

Tanner Pain Management Center
150 Henry Burson Dr. Suite 110
Carrollton, GA 30117
770–812–5720

The purpose for this agreement is to safeguard the patient access to controlled substances and protect Tanner Pain Management Center's ability to prescribe them.

The long term use of substances such as opioids (NARCOTIC ANALGESICS), benzodiazapines, tranquilizers, and barbiturate sedatives have a potential for misuse and are therefore controlled by local, state, and federal government. There is also a risk of an addictive disorder developing or a relapse occurring in a person with a prior addiction. The extent of this risk is uncertain. Physical dependence is common to many drugs. Addiction is a psychological and behavioral syndrome that is recognized when the patient uses the drug to obtain mental numbness or euphoria; when the drug is quickly escalated without correlation to pain relief. While physical dependence is to be expected after long term use of opioids, signs of addiction (and psychological dependence) will be interpreted as a need for weaning and detoxification. Pain management patients will adhere to the physician's guidance and participate in a treatment plan that may include detoxification, psychological counseling, and medical treatment. Failure to comply will result in discharge.

Because these drugs have a potential for abuse or diversion, strict policies must be in place and adhered to by the prescribing physician. Failure for the patient to abide in these policies may result in discharge from the pain management center.

It is important to be aware of possible side effects of these medications. Common side effects could include nausea, vomiting, drowsiness, mental slowing, flushing, itching, difficulty urinating and perspiring. While these mediations are not generally toxic to the body organs, they can suppress breathing and may be fatal to a non–tolerant person. ESPECIALLY A CHILD. Drowsiness and impaired concentration may create danger with driving or operating machinery. The most common side effect is constipation. This side effect does not usually spontaneously resolve. Stool softeners or other agents may be required for resolution. It is very important to monitor this function.

1. **ALL CONTROLLED SUBSTANCES MUST BE ORDERED BY THE PAIN MANAGEMENT SPECIALIST ONLY, UNLESS SPECIFIC AUTHORIZATION IS OBTAINED FOR AN EXEMPTION. MULTIPLE SOURCES OF NARCOTIC MEDICATION CAN LEAD TO ADVERSE DRUG INTERACTION, OVERDOSE OR DEATH.**
2. **ALL MEDICATIONS MUST BE OBTAINED FROM ONE PHARMACY. SHOULD A CHANGE ARISE, THE PAIN MANAGEMENT CENTER MUST BE NOTIFIED IMMEDIATELY.**

PHARMACY CHOICE _____

TELEPHONE NUMBER _____

3. NO ILLEGAL substances may be used.
4. Disclosure of any new medications, medical conditions or adverse reaction to prescribed medications must be given to the pain management center.
5. The prescribing physician has permission to discuss all diagnostic and treatment plans with dispensing pharmacists or other professionals for the purpose of maintaining accountability.
6. Patients will not share, sell or permit others access to these medications.
7. Abruptly stopping these medications may cause withdrawal symptoms. Withdrawal symptoms may include: yawning, sweating, anxiety, tremors, muscle aches, hot or cold flashes, abdominal cramping, and diarrhea. These symptoms may occur 24 – 48 hours after last dose and may last up to three weeks.
8. Random drug screens will be performed. Failure to provide WILL result in IMMEDIATE DISCHARGE.
9. Prescriptions and medications may be sought after by other individuals. These items should be carefully safeguarded. If medications/prescriptions are stolen , a police report must be provided for consideration of medication replacement.
10. Medications may not be replaced if lost, destroyed, or misplaced.
11. Early refills generally will NOT occur.
12. If responsible legal authorities have questions concerning a patient's medication regime, the pain center will provide information required.
13. Prescription refills must be requested **THREE WORKING DAYS IN ADVANCE.** Failure to provide appropriate notice may result in delay of treatment plan. Prescriptions will not be available on the weekends, after office hours, or on holidays.
14. Changes to prescription medications (medication, dosage, strength, etc) will generally not be made by phone. Please make an appointment for medication changes.
15. Prescription refills are contingent with keeping scheduled appointments: Federal Law dictates that patients must visit their physician every two months to receive narcotics.
16. Failure to adhere to these policies may result in cessation of therapy with controlled substances or discharge.
17. It is understood that any medical treatment is initially a trial and continued prescription is dependant on evidence of benefit.
18. Increasing the amount of medication without physician supervision or improper usage of medication can lead to drug overdose, respiratory depression, or death.

I have read the provided information and have been given the opportunity to ask questions. I agree to the above conditions.

Patient Signature _____ Date _____

Tanner Medical Center, Inc.

Tanner Pain Management Center
150 Henry Burson Dr. Suite 110
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Thank you for choosing Tanner Pain Management Center for treatment. Our mission is to return you to the highest activity and comfort level possible. Treatment is provided by a coordinated, goal directed team. This team consists of a collaboration of the pain management staff, ancillary departments, outside agencies, and the patient. The patient is the MOST important team member. It is essential for the patient to actively participate in the treatment plan.

Pain Management Staff Commitment:

1. The PMC physician will provide a detailed evaluation with treatment recommendations.
2. The PMC staff will provide explanation of treatments and expected Outcomes of treatments.
3. The PMC staff will assist in pre–certification of procedures and explanation of benefits prior to initiation of treatment.
4. The PMC staff maintains strict adherence to confidentiality of medical records and conversations.

Patient Commitment:

1. The patient will maintain strict adherence to the Orientation Agreement.
2. Appointment commitment:
    a. Due to set scheduling, the patient will be rescheduled if more than fifteen minutes late for appointment.
    b. Patients that do not show or cancel appointments without an adequate reason may be discharged after the second incident.
3. Non–compliance to the treatment plan; i.e. therapies, consultations, medications, etc. or not showing for these appointments will result in discharge from the center.
4. The patient will provide adherence to the medication regime as directed by the physician.
5. A "Controlled Substance" agreement will be signed.

6. Refusal to comply with baseline and/or random drug screening request will result in discharge from the center. If non–declared or illegal substances are resulted, the patient will be referred to a substance abuse treatment center. Failure to comply with treatment, future positive drug screens or requested pill counts will result in discharge. Counseling will occur if inadequate levels of prescribed medication are resulted. If subsequent screening results in inadequate medication levels, the patient will be discharged.
7. To maintain prescription refills, patients MUST be evaluated as directed by the PMC physician.
8. ******Prescription refill requests must be made 3 working days in Advance. ******
9. Abusive language, aggressive behavior and/or harassment of the PMC staff will result in immediate discharge.
10. The patient will provide prompt updating of any change in demographic or insurance information.
11. The patient agrees to permit the PMC to access and provide medical records to referring, consulting and/or primary care physicians and to ordered therapies associated with treatment plan.
12. The patient permits general messages from the PMC to be left on answering machine or voice mail at the patient's provided telephone number. (Medical information will NOT be stated).

I have been given the opportunity to ask questions regarding the above agreement. I understand the commitment to the pain management program and to the treatment plan. I agree, within the best of my ability, to adhere to these commitments.

Patient Signature _____ Date _____

TANNER PAIN MANAGEMENT
PATIENT HISTORY

NAME_____DATE OF BIRTH_____

PRIMARY CARE PHYSICIAN_____REFERRING PHYSICIAN_____

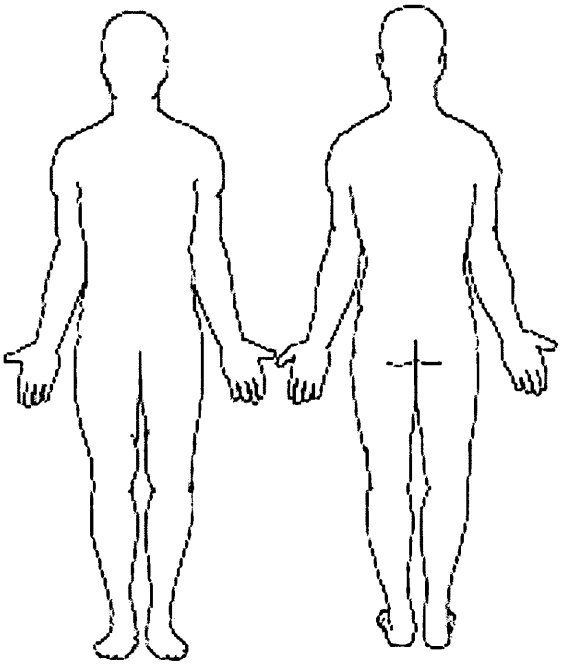
DESCRIPTION OF PAIN (CIRCLE ALL THAT APPLY)

1. I AM HERE FOR EVALUATION OF (NECK, SHOULDER, LOWER BACK, HIP, KNEE, FOOT, OR _____)PAIN.
2. PAIN IS LOCATED IN _____AND SPREADS TO (LEFT, RIGHT, BOTH, ARM, HIP, LEG).
3. WHEN DID THE PAIN BEGIN AND WHAT CAUSED IT?_____.
4. DESCRIPTION OF PAIN IS(ACHE, PINS/NEEDLES, STABBING, BURNING, VIBRATION, NUMBNESS, PRESSURE, COLD, HOT, OTHER_____.
5. WHAT IS YOUR PAIN SCALE NOW?_____

0	1	2	3	4	5	6	7	8	9	10
NONE	**MILD**				**MODERATE**				**SEVERE**	

6. WHAT IS YOUR PAIN SCALE ON YOUR BEST DAY?_____
7. WHAT IS YOUR PAIN SCALE ON YOUR WORST DAY?_____
8. INDICATE ON THE DIAGRAM WHERE YOUR WORST PAIN IS LOCATED.

RIGHT LEFT RIGHT



9. MY PAIN (MILDLY, MODERATELY, SEVERLY, VERY SEVERLY) INTERFERES WITH MY ACTIVITIES OF DAILY LIVING.
10. IS YOUR PAIN ASSOCIATED WITH WEAKNESS?_____WHERE_____
11. IS YOUR PAIN ASSOCIATED WITH NUMBNESS?_____WHERE_____
12. IS YOUR PAIN ASSOCIATED WITH TINGLING?_____WHERE_____
13. DO YOU HAVE ANY SKIN COLOR OR TEMPERATURE CHANGE?_____WHERE?_____
14. I AM HYPERSENSITIVE TO (TOUCH, CLOTHES, COLD, WEATHER CHANGES).
15. DO YOU HAVE INCONTINENCE, CONSTIPATION OR LOSS OF CONTROL OF BLADDER OR BOWELS?_____

16. HOW MANY HOURS OF UNINTERRUPTED SLEEP DO YOU HAVE AT NIGHT?_____DO YOU FEEL RESTED IN THE MORNING?_____DO YOU HAVE NIGHT PAIN?_____

PREVIOUS TREATMENTS/CONDITIONS

17. CIRCLE THE PREVIOUS TREATMENTS/MEDICATIONS YOU HAVE TRIED; INDICATE DATE IF YOU KNOW.
    DOCTOR:NAME_____
    PAIN SPECIALIST:NAME_____
    PHYSICAL THERAPY:_____DID IT HELP?_____
    ACCUPUNCTURE:_____DID IT HELP?_____
    EPIDURAL INJECTION/NERVE BLOCK:_____DID IT HELP?_____
    NERVE STIMULATOR:_____DID IT HELP?_____
    CHIROPRACTOR: _____DID IT HELP_____
    PREVIOUS NECK/BACK/HIP/KNEE SURGERY:TYPE OF SURGERY/DATE_____
    MEDICATION:ALEVE, ANTI-INFLAMMATORY, ASPIRIN, CELEBREX, CYMBALTA, DILAUDID, HYDROCODONE, IBUPROFEN, LYRICA, METHADONE, MOBIC, MORPHINE, MOTRIN, MUSCLE RELAXERS, NAPROSYN, NAPROXEN, NEUROTIN, OXYCODONE, OXYCONTIN, TYLENOL, VOLTAREN
18. WHAT TESTS HAVE YOU HAD? INDICATE DATE AND RESULTS IF YOU KNOW THEM:
    X-RAY_____
    MRI_____
    CAT SCAN_____
    MYELOGRAM_____
    EMG/NCS_____
19. DO YOU HAVE ANY OF THE FOLLOWING:
    AGE GREATER THAN 50
    HISTORY OF COLON CANCER:DATE_____
    NEUROLOGICAL DISORDERS(SEIZURES, MULTIPLE SCLEROSIS, MYOPATHIES, NEUROPATHIES)
    UNINTENTIONAL WEIGHT LOSS
    DIABETES
20. PLEASE LIST ANY MEDICAL CONDITIONS YOU HAVE AND THE TREATMENT YOU HAVE RECEIVED:_____
    _____
    _____
    _____
    _____
21. PLEASE LIST ANY SURGERIES YOU HAVE HAD AND THE YEAR PERFORMED:_____
    _____
    _____
    _____
    _____
22. DO YOU USE ALCOHOL, TOBACCO, ILLEGAL DRUGS, MARIJUANA? IF YES, PLEASE LIST PRODUCTS AND HOW OFTEN THEY ARE USED:_____
    _____
    _____
23. DO YOU HAVE DEPRESSION OR A HISTORY OF DEPRESSION?_____ARE YOU PRESENTLY BEING TREATED FOR DEPRESSION?_____
24. IN THE PAST YEAR HAVE YOU EXPERIENCED ANY PYSICAL, EMOTIONAL, VERBAL, OR SEXUAL ABUSE?_____
25. MARITAL STATUS:_____DO YOU LIVE ALONE?_____
26. DO YOU HAVE CHILDREN LIVING AT HOME?_____WHAT ARE THEIR AGES?_____
27. ARE YOU PRESENTLY INVOLVED IN A LAWSUIT? IF YES, EXPLAIN_____
28. ARE YOU PRESENTLY ON DISABILITY?_____ ARE YOU SEEKING DISABILITY?_____

29. PLEASE LIST ANY MEDICATION ALLERGIES:_____

30. LIST **ALL** THE MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING PRESCRIPTION DRUGS, HERBS, SUPPLEMENTS AND OVER THE COUNTER. PHARMACY:_____

PHARMACY TELEPHONE:_____

MEDICATION	DOSAGE	DIRECTIONS

PATIENT SIGNATURE_____DATE_____

TANNER HEALTH SYSTEM

PATIENT REGISTRATION

Welcome! As a member of the Tanner Pain Management, we are committed to providing the best and most comprehensive healthcare possible. We encourage you to ask questions. Please assist us by providing the following information- a copy of your driver's license and primary and secondary insurance cards. All information is confidential and is released only with your consent.

PATIENT INFORMATION

Patient's Name: _____ Preferred Pharmacy: _____

Date of Birth: _____ Social Security #: _____

Race: American Indian or Alaska Native Asian Black or African American Hispanic or Latino

Native Hawaiian or Other Pacific Islander White or Caucasian Other_____

Current Primary Care Doctor: _____ Sex: Male Female

Marital Status: Married Single Widow Divorced

Patient's Address: _____ Home#: _____

_____ Work#: _____

Email: _____ Cell#: _____

INSURANCE INFORMATION

Primary Insurance: _____ Primary Cardholder's Name: _____

Date of Birth: _____ Social Security #:_____ Relationship: _____

Secondary Insurance: _____ Primary Cardholder's Name: _____

Date of Birth: _____ Social Security #:_____ Relationship: _____

Were you injured on the job? Yes No Is this visit a result of a Motor Vehicle Accident? Yes No

PATIENT IDENTIFICATION NUMBER

In order to better protect your privacy, please choose a Patient Identification Number (PIN) to further identify yourself when calling the office or when the specified third parties need to access your personal health information.

YOUR PERSONAL IDENTIFICATION NUMBER (PIN) IS _____

By disclosing the PIN number listed above, the following person(s) may discuss and/or release my protected health information to include: Test Results Appointment Information Rx Requests and Information Billing Account Information Test Preparation Information and Patient Instructions Treatment Plan Information

1. Name:_____ DOB:_____ phone number:_____

2. Name:_____ DOB:_____ phone number:_____

3. Name:_____ DOB:_____ phone number:_____

_____ _____

Patient's/Legal Guardian's Signature Date

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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