

**Arnold-Warfield Pain Management Center**  
 One Brookline Place, Suite 105  
 Brookline, MA 02445  
**TEL: (617) 278-8000**  
**FAX: (617) 754-8634**

## Arnold-Warfield Pain Management Center CLINICAL ORDER

**PLEASE PRINT CLEARLY AND COMPLETE ALL INFORMATION**

*Thank you for referring your patient to the Arnold-Warfield Pain Management Center. In order to treat your patient in a timely and effective manner, please complete the information requested below as thoroughly as possible. **PLEASE NOTE:** The Arnold- Warfield Pain Management Center **does not** accept referrals for long-term opioid management. Patients currently on opioid therapy may be evaluated for **consultation or alternative therapies only** but will not receive prescriptions for opioids. They will be referred back to the primary care for ongoing management. Additionally, please fill out the attached **Consultation for Patients Receiving Chronic Opioid Therapy** form if a consult is being requested.*

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Insurance: \_\_\_\_\_

Reason for Referral: (please circle)	Acute	Chronic	Urgent
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Duration of Symptoms: \_\_\_\_\_ Description of Symptoms: \_\_\_\_\_

Current Medications – Please list all medications & dosage or attach a medication sheet:

CT, MRI Results – Please attach any reports and have patient bring films or images:

Previous Treatments: (please circle)	PT/OT	Acupuncture	Chiropractic	Epidural Injections
	Other Injections:		Other Pain Clinic:	

Expectation for Treatment at APMC: \_\_\_\_\_

Past Medical Hx: \_\_\_\_\_

Past Social/Psychiatric Hx: \_\_\_\_\_

Other Pertinent Data – Please include any other notes or records pertaining to any allergies or medical history that would be helpful in assessing your patients medical condition: \_\_\_\_\_

**To ensure that all clinical notes are mailed to the proper address, please complete the following:**

Referring Physician (please print): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

## Arnold-Warfield Pain Management Center

### Consultation Services for Patients Receiving Chronic Opioid Therapy

**Please Note:** So that we can complete a meaningful consultation for both you and your patient, we **REQUIRE** that a completed copy of this form is returned with your request for any consultation regarding chronic opioid therapy.

We aim to assist patients and their providers in understanding how and when to use opioids for the long-term treatment of chronic pain.

We are frequently asked to assist with chronic opioid therapy. Because there are so many providers requesting consultative services, we cannot assume primary prescribing responsibility for this therapy. Nonetheless, we are here to help you. Please help us understand how we can best assist you in the care of your patient by directing our attention to one of the following areas:

- **WHAT IS THE BEST OPIOID TO USE?** Is this the best drug(s) for my patient? Please assess the drug/drug combination that this patient is receiving and help me optimize.
- **SHOULD I START OPIOIDS AT ALL?** I have not yet started chronic opioid therapy. Is chronic opioid therapy appropriate for my patient?
- **SHOULD I CONTINUE OPIOIDS?** I have already started chronic opioid therapy and I am uncertain that I should continue this therapy. Please assess this patient and provide feedback about the use of opioids in treating his/her ongoing pain. [Please provide specific details regarding any problems with compliance.]
- **HOW CAN I IMPROVE ADHERENCE AND OUTCOME?** I am starting a patient on opioids or already have a patient with possible risk factors. What are the specific steps that I can take to better insure adherence to the prescribed regimen? How can I maximize the likelihood that the patient will achieve adequate gains with respect to pain relief and improved function?
- **I THINK MY PATIENT IS ADDICTED TO OPIOIDS. WHAT SHOULD I DO?** I have already started chronic opioid therapy and I am concerned that my patient is showing signs of addiction. How should I proceed? [Please provide specific details regarding any signs or symptoms of addiction that you have detected or suspected.]

Thank you for your referral. We will make every effort to directly assess your specific questions during the consultation and return our suggestions to you promptly. Please do not hesitate to call the consultant in our center directly, if you have additional questions after your patient has been evaluated.

Name of provider requesting consultation (please print): \_\_\_\_\_

Facsimile number of provider requesting consultation: \_\_\_\_\_