**Treatment of Chronic Pain and Opioid Management**

**CASE PRESENTATION FORM**

**Return completed forms to** **ahec@uvm.edu** **or fax 802-656-3016.**

**Patient Initials:** Click or tap here to enter text.

**Provider Name:** Click or tap here to enter text.

**Provider Practice/City or Town:** Click or tap here to enter text.

**Provider Phone Number:** Click or tap here to enter text.

**Provider Email:** Click or tap here to enter text.

**Does your case focus on one of the planned topics? If yes, provide session topic:** Click or tap here to enter text.

**Which date would you ideally like to present your case?** Click or tap to enter a date.

|  |  |
| --- | --- |
| **Date** | **Session Topic** |
| April 20 | Opioid-prescribing Best Practices |
| May 4 | Functional Assessment |
| May 18 | Assessment for Misuse |
| June 1 | Urine Drug Testing |
| June 15 | Compassionate Tapering |
| June 29 | Non-opioid Treatments |
| July 13 | Interventional Pain Management |
| July 27 | Cannabis Use for Chronic Pain |

**ECHO ID#** *To be provided by ECHO.*

**Presentation Date** **Presenter**

*To be provided by ECHO* *To be provided by ECHO*

**Patient Age**

Click or tap here to enter text.

**Body Mass Index (BMI)**

Click or tap here to enter text.

**Patient Gender**

[ ]  Male [ ]  Female [ ]  Other Click or tap here to enter text.

**Please state your question(s) for the UVM ECHO**

**Specific Requests**

[ ]  Help with diagnosis/test interpretation

[ ]  Help with pharmacologic treatment

[ ]  Help with non-pharmacologic treatment

[ ]  Other Click or tap here to enter text.

**Pain Location Pain Characteristic Duration of Pain**

[ ]  Head [ ]  Constant [ ]  Months

[ ]  Neck [ ]  Intermittent [ ]  Years

[ ]  Upper Back **Pain Quality**

[ ]  Lower Back [ ]  Aching

[ ]  Abdomen [ ]  Burning

[ ]  Pelvic [ ]  Sharp

[ ]  Upper Extremity [ ]  Dull

[ ]  Lower Extremity [ ]  Associated Numbness/Tingling

Additional Information: Click or tap here to enter text.

**Working Diagnosis**

[ ]  Myofascial Pain/Fibromyalgia

[ ]  Arthritis

 [ ]  Degenerative/Osteoarthritis

 [ ]  Inflammatory/Rheumatoid

[ ]  Peripheral Neuropathy

[ ]  Chronic abdominal and/or pelvic pain

[ ]  Headache

 [ ]  Migraine

 [ ]  Chronic daily headache

[ ]  Other Click or tap here to enter text.

**Functional Status:** Click or tap here to enter text.

**Average Pain Rating (0-10):** Click or tap here to enter text.

**What alleviates the pain?** Click or tap here to enter text.

**What exacerbates the pain?** Click or tap here to enter text.

**Associated symptoms**

[ ]  Sleep disruption [ ]  Fatigue [ ]  Sexual Dysfunction

[ ]  Depressed mood

[ ]  Others Click or tap here to enter text.

**Current Medications**  **Pertinent Past Medical/Surgical Hx**

**Medications tried in past**

[ ]  **NSAID**  [ ]  **Opioid**  [ ]  **Anticonvulsant**

 [ ] Ibuprofen/Naproxen [ ]  Oxycodone [ ]  Gabapentin

 [ ] Celecoxib [ ]  Hydromorphone [ ]  Pregabablin

 [ ] Meloxicam [ ]  Hydrocodone

[ ]  **Acetaminophen** [ ]  Morphine [ ]  **Antidepressant**

[ ]  **Muscle relaxant**  [ ]  Tramadol [ ]  SSRI

 [ ]  Cyclobenzaprine [ ]  Fentanyl [ ]  TCA

 [ ]  Tizanadine MME: Click or tap here to enter text. [ ]  SNRI

 [ ]  Methocarbamol

[ ]  **Others:** Click or tap here to enter text.

**Pertinent Physical Exam**

**ECHO ID:** Click or tap here to enter text.

**Diagnostic Testing**

[ ]  X-ray Click or tap here to enter text.

[ ]  CT scan Click or tap here to enter text.

[ ]  MRI Click or tap here to enter text.

[ ]  EMG/NCV

[ ]  LabsClick or tap here to enter text.

**Pertinent Results**

**Non-Medication Interventions Procedural Interventions**

[ ] Physical Therapy [ ]  Epidural Steroid

[ ] TENS [ ]  Medical Branch Block

[ ] Water Therapy [ ]  Radiofrequency Ablation

[ ] Acupuncture [ ]  Selective nerve block

[ ] Chiropractic/Osteopathic Click or tap here to enter text.

[ ] Counseling/Psychology [ ]  Spinal Cord Stimulator

[ ] Massage

[ ] Yoga

**Outcomes of Interventions**

Physical

Therapy

TENS

Water

**Screening Tools/Assessments**

[ ]  PHQ-9 Click or tap here to enter text.

[ ]  GAD-7 Click or tap here to enter text.

[ ]  SOAPP/ORT Click or tap here to enter text.

[ ]  COMM Click or tap here to enter text.

[ ]  Urine Drug Testing Click or tap here to enter text.

[ ]  Other Click or tap here to enter text.

**Goals**

**Current Diagnostic/Treatment Plan**