**Treatment of Chronic Pain and Opioid Management**

**CASE PRESENTATION FORM**

**Return completed forms to** [**ahec@uvm.edu**](mailto: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**