FAX

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REMARKS: ❑ Urgent ❑ For your review ❑ Reply ASAP ❑ Please comment

Pain Assessment for: (name) _____ DOB ___/___/___ MR# _____

Diagnosis: _____

Location(s) 1. _____ 2. _____

Description (Quality) 1. _____ 2. _____

Intensity (0-10,0-5, etc) 1. _____ 2. _____

Frequency/Pattern 1. ❑Continuous❑Intermittent 2. ❑Continuous❑Intermittent

Onset 1. _____ 2. _____

Duration 1. _____ 2. _____

Exacerbating factors 1. _____ 2. _____

Impact on ADLs 1. _____ 2. _____

Vital signs: T _____ P _____ R _____ BP: L _____ R _____

Orthostatic monitoring: **recumbent** for at least 5 minutes BP: L _____ R _____

standing 1 minute L _____ R _____ 5 minutes L _____ R _____

Drug side effects: (check all that apply) ❑ Constipation ❑ Lethargy ❑ Confusion ❑ Increase agitated behavior ❑ New cognitive decline ❑ Falls ❑ Dizziness ❑ Orthostatic hypotension ❑ Anorexia ❑ Weight loss ❑ Nausea ❑ Vomiting ❑ GI bleed ❑ Urinary retention ❑ Painful urination ❑ Insomnia ❑ Sleep disturbances ❑ Headache ❑ Unexplained or diffuse, painful, pruritic rash

Resident's perception of what is causing the pain: _____

Resident's goal for pain control: _____ (numerical) _____ (functional)

Drug, dosage, and # of doses received of all analgesic medications in the past 24 hours: _____

_____

_____

Analgesics that have been tried in the past: _____

Non-pharmalogical interventions tried: ❑ Warm packs ❑ Cold packs ❑ Breathing and relaxation ❑ Music tapes ❑ Reading ❑ Massage ❑ Guided Imagery ❑ Moving to a less stimulating environment ❑ Distraction ❑ Repositioning ❑ Other: _____

Team suggestions for changes in management: New meds/dosages/intervals _____

_____ Discontinue: _____

RN Signature: _____ Pharmacist Signature: _____

MD Response: _____

_____

_____

MD Signature: _____ Print name: _____

Date: _____ DEA #: _____

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