MERCY INTERVENTIONAL PAIN MANAGEMENT CLINIC

Pain Clinic Instructions

1.) Your appointment is scheduled on ______________________

You must **ARRIVE** at the Pain Clinic at ____________ procedure to take place at ____________

Please call 319-398-6636 and speak with the Scheduling Coordinator if you need to reschedule. A fee will apply if you miss this appointment without providing 24 hours notice.

2.) If an injection is done, patients **must**:
- Have a driver available to take them home
- Have a responsible adult stay with you for 24 hours after the procedure if receiving sedation

3.) Please complete the attached Pain Assessment form prior to arriving at the pain clinic. If you do not have this form filled out, you will need **to arrive 15 minutes earlier** to complete the form prior to admission

4.) Eating/Drinking Instructions (if a procedure is to be performed)
- NO solid food or dairy 6 hours prior to procedure
- Clear liquids up to 3 hours prior to your arrival time
- **(This means nothing by mouth 3 hours prior to your arrival time)**

5.) Medications:
- If you are prescribed any blood thinners such as Coumadin, Plavix, Xarelto, Eliquis, Pradaxa, Effient, Brilinta, etc. please hold medication for requested time. Call pain clinic and select option 4 to speak with a nurse should you have any questions.
- Aspirin: Do NOT take any aspirin or aspirin-containing products during the 72 hours prior to your appointment. This includes Excedrin, Bayer, and Bufferin.
- Other pain medicines such as ibuprofen, acetaminophen, naproxen, etc. may be taken as needed through your appointment time.
- If you have an infection, are running a temperature, or taking an antibiotic, please call pain clinic and speak with a nurse.

  Still have questions regarding medications? Call 319-398-6636 and select option 4 to speak with a nurse

6.) Diabetics: If you need instruction for your medications, call 319-398-6636 and select option 4 to speak with a nurse 2 days prior to your appointment

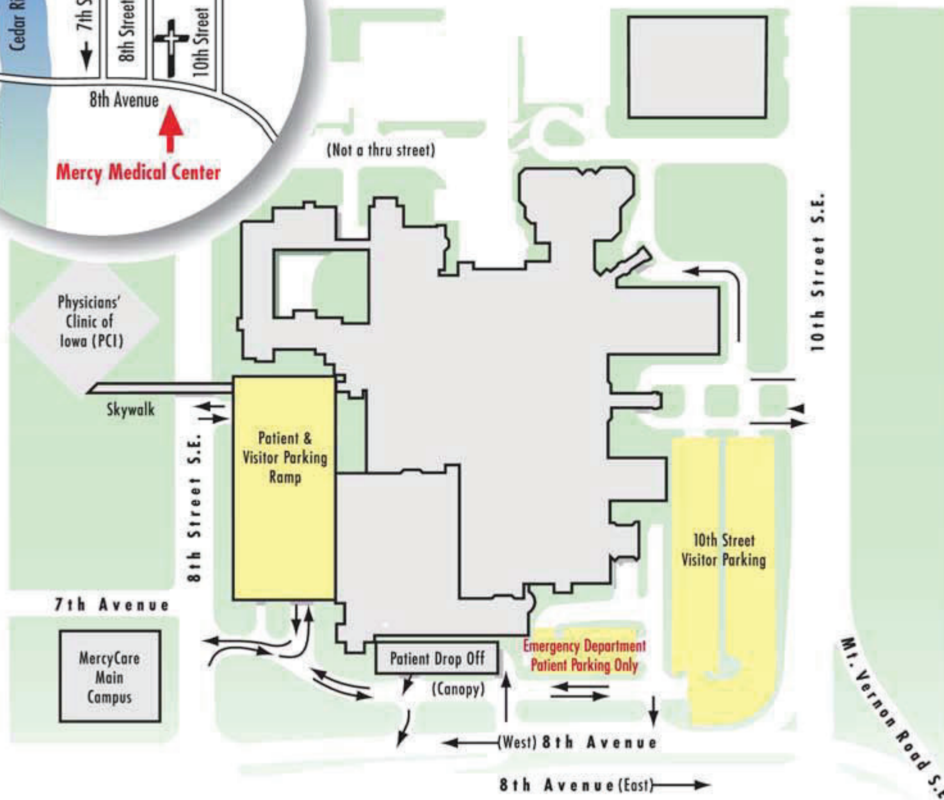
7.) Mercy Medical Center's Pre-Authorization Department will contact your insurance company to obtain authorization for each procedure. Authorization times are dependent upon your insurance coverage. The Pain Clinic will contact you if there is an issue with authorization. As a patient, however, YOU are responsible for learning the out of pocket cost, if any, for each procedure

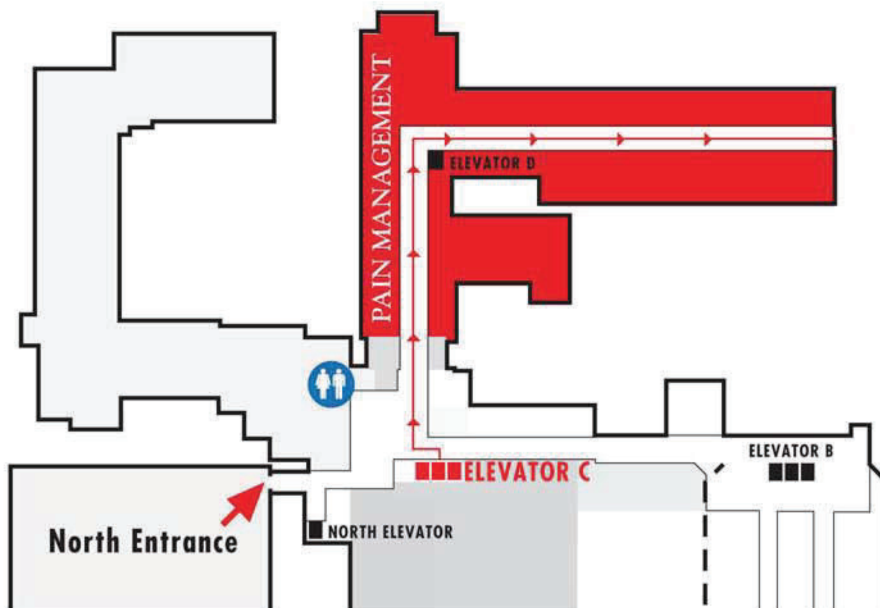
8.) If you still have questions regarding your upcoming procedure, please call Mercy Interventional Pain Management Clinic at 319-398-6636 or visit our website at cr-anesthesia.com

painMANAGEMENT

One out of every three people will suffer chronic pain at some point in their lives. If you suffer from acute or chronic pain that interferes with your enjoying life, Mercy's Pain Management Services may be able to help.

701 10th Street SE
Cedar Rapids, Iowa 52403
(319) 398-6011 • *www.mercycare.org*





HOW TO FIND US

From Highway 30 East or West

Take the I-380 N exit.

Approaching from the South (on I-380)

Heading northbound on I-380, take the Diagonal Drive exit (#19A) and turn right (east). Diagonal Drive curves left over the Cedar River and turns into 8th Avenue SE. Mercy is about 8 blocks on your left. (Turn left on 8th Street to access the parking ramp.)

Approaching from the North (on I-380)

Heading southbound on I-380, take the 7th Street exit (#20B). Stay on 7th Street heading south for about 9 blocks. Turn left (east) on 8th Avenue SE. Mercy is one block on your left. (Turn left on 8th Street to access the parking ramp.)

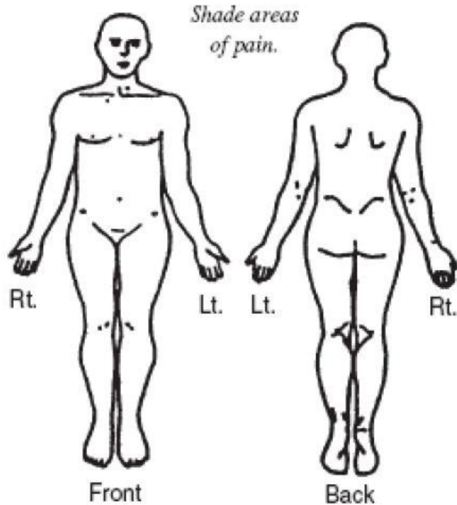
Parking/Directions to the Pain Clinic

Park in the 8th Street parking ramp (accessible from either 8th Street or 8th Avenue). You may park on any level (ground through 3rd floor) and enter the building at the North entrance. Take the "C" elevator to the 4th floor. Reserved parking is available at the North entrance of the 3rd floor and is marked "Pain Management."

Pain Management Services Pain Assessment

1. Where is your worst pain located? ________________
2. Does it spread, and if so, where? ________________

____



3. **When** did your pain begin? ____________________
4. When did it get worse? ______________________
5. Is your pain related to an injury or accident?
   ____
6. Is your pain continuous, or does it come and go?_____
7. Describe in your own words what your pain feels like:
   ____
8. Rate your pain today:___________________(0-10)
9. Indicate the **range** of your pain:
   0 1 2 3 4 5 6 7 8 9 10
   No pain Worst Pain Imaginable
10. Best position for comfort:
    (circle) lying standing sitting
11. Most painful position:
    (circle) lying standing sitting
12. What makes your pain better? _________________
    ____
13. What makes your pain worse? ________________
    ____
14. Current pain medications: ____________________
    ____

15. What **treatment(s)/surgeries** have you received for this pain in the past? _________________________
    ____
16. Previous x-ray scans, related to present pain:
    MRI/CT/XRAY: ______________________________
    Where: ____________________________________
17. Does your pain effect your: (if yes, how?)
    - Sleep: No / Yes, _________________________
    - Appetite: No / Yes, ______________________
    - Physical Activity: No / Yes, ________________
    - Social Activity: No / Yes, _________________
18. Working: (circle) NO YES
    - Occupation: _____________________________
    - Restrictions: ____________________________
    - Have you missed work: ___________________
    - Last day worked: ________________________
    - Is this a Workmen's Compensation claim?
      NO YES
    - If yes, who is your case manager? ___________
    - Case Manager's phone number: ____________
19. Following your last visit to the Pain Clinic:
    - Was there an improvement in your pain?
      ____
    - Indicate best pain score or percent improvement
      ____
    - If so, how long did the improvement last?
      ____
    - Has your activity level changed?
      ____
    - Has your pain changed since your last visit?
      ____
20. Have you had a **new** MRI/CT/XRAY since your last visit? _________________________________
21. **New** tests since last seen? ____________________
    ____
22. List any changes in medications or medical history since **last** visit: ______________________________
    ____
23. As a result of your previous treatment, has there been improvement in your quality of life?
    ____
24. If applicable, have you been able to return to work?
    ____

PAIN ASSESSMENT

PC-PDF-15 Rev 10/19

PATIENT LABEL

25. Change in control of bowel or bladder? _______
____
26. Unexplained weight loss or gain? ___________
____
27. Do you have any bleeding problems? ________
____
28. Do you have any of the following: (circle)
Fever *Productive Cough* *Sore Throat*
Sinus Infection *Burning with Urination*
29. Are you on an antibiotic? _________________

30. Do you take a blood thinner or aspirin? (circle) NO YES
- List blood thinner: NAME LAST TAKEN
1. ______________________
2. ______________________

31. Is there a chance you are pregnant? (circle) NO YES
32. Use of tobacco products:
(circle) NO YES,_____packs/day
33. Use alcohol: (circle) NO YES,_____drinks/day
34. Have you had a drug/alcohol problem? _____________
35. Use illegal drugs: (circle) NO YES, ______________

*****Fill this section out if *****
first visit for current issue

Medical History

Do you have or are you currently being treated for:
(Circle No or Yes: Check if applicable)

			New	History Of
Anemia	No	Yes	___	____
Arthritis	No	Yes	___	____
Asthma	No	Yes	___	____
Back Problems	No	Yes	___	____
Blood Disorder	No	Yes	___	____
Bruising	No	Yes	___	____
Cancer	No	Yes	___	____
Cataracts	No	Yes	___	____
Circulation Problems	No	Yes	___	____
Diabetes	No	Yes	___	____
Glaucoma	No	Yes	___	____
Headaches	No	Yes	___	____
Heart Disease	No	Yes	___	____
Heart Failure	No	Yes	___	____
High Blood Pressure	No	Yes	___	____
HIV	No	Yes	___	____
Kidney Disease	No	Yes	___	____
Lung Disease	No	Yes	___	____
Osteoporosis	No	Yes	___	____
Seizures	No	Yes	___	____
Stroke	No	Yes	___	____
Stomach Ulcers	No	Yes	___	____
TB	No	Yes	___	____
Thyroid Disorder	No	Yes	___	____
Spine Disease	No	Yes	___	____

Family History:

Spine Disease	No	Yes	Who: _______
Drug/Alcohol Abuse	No	Yes	Who: _______

Surgical History: ____________________________
____
____

See Medication List

Review of Systems

Presently experiencing any of the following symptoms?
(Circle No or Yes)

Constitutional Symptom:

Fever	No	Yes
Chills	No	Yes
Headaches	No	Yes

Other: ___________________

Eyes:

Blurred Vision	No	Yes
Double Vision	No	Yes

Other: ___________________

Pulmonary:

Wheezing	No	Yes
Frequent Cough	No	Yes
Shortness of Breath	No	Yes

Other: ___________________

Neurological:

Weakness	No	Yes
Dizziness	No	Yes
Numbness/ Tingling	No	Yes

Other: ___________________

Psychological:

Severe Depression	No	Yes
Suicidal Thoughts	No	Yes
Confusion	No	Yes
Sleep Disturbance	No	Yes

Other: ___________________

Genitourinary:

Painful Urination	No	Yes
Blood in Urine	No	Yes

Other: ___________________

Ear/Nose/ Throat/Mouth:

Ear Pain	No	Yes
Decreased Hearing	No	Yes

Other: ___________________

Cardiovascular:

Chest Pain	No	Yes
Fluid Retention	No	Yes

Other: ___________________

Gastrointestinal:

Abdominal Pain	No	Yes
Nausea/Vomiting	No	Yes
Indigestion/ Heartburn	No	Yes

Other: ___________________

Musculoskeletal:

Joint Pain	No	Yes
Swelling	No	Yes
Neck Pain	No	Yes
Joint Stiffness	No	Yes

Other: ___________________

Hematological:

Swollen Glands	No	Yes
Bruising	No	Yes
Unusual Bleeding	No	Yes
Rectal Bleeding	No	Yes
Frequent Infection	No	Yes

Other: ___________________

Patient Signature: ______________________________

PATIENT LABEL