

Nursing Home Communication with Physician - Pain Management

Resident: _____ Age _____ Sex _____ Date: _____

Diagnoses: _____

Reason for contact: New Onset Change in Pain Other

Pain Assessment

Current pain medication/treatment: _____

Other medication/treatment: _____

Allergies: _____

Location of pain: _____

Brief pain history: _____

Current Vital Signs and relevant physical findings:

Temp: _____ Pulse: _____ Resp: _____ BP: _____/_____

Location 1	Description of Pain:	Affect on resident:	Location 2	Description of Pain:	Affect on resident:
(check all that apply)	<input type="checkbox"/> Dull ache <input type="checkbox"/> Throbbing <input type="checkbox"/> Pressure/heaviness <input type="checkbox"/> Burning <input type="checkbox"/> Shooting <input type="checkbox"/> Sharp <input type="checkbox"/> Comes and goes <input type="checkbox"/> Always present <input type="checkbox"/> Localized <input type="checkbox"/> Radiates <input type="checkbox"/> Other	<input type="checkbox"/> Appetite <input type="checkbox"/> Mood <input type="checkbox"/> Activity <input type="checkbox"/> Sleep	(check all that apply)	<input type="checkbox"/> Dull ache <input type="checkbox"/> Throbbing <input type="checkbox"/> Pressure/heaviness <input type="checkbox"/> Burning <input type="checkbox"/> Shooting <input type="checkbox"/> Sharp <input type="checkbox"/> Comes and goes <input type="checkbox"/> Always present <input type="checkbox"/> Localized <input type="checkbox"/> Radiates <input type="checkbox"/> Other	<input type="checkbox"/> Appetite <input type="checkbox"/> Mood <input type="checkbox"/> Activity <input type="checkbox"/> Sleep

Score on pain scale*

Score on pain scale*

Pain medication last given: _____

Pain medication last given: _____

Pain relieved according to resident goal? Yes No

Pain relieved according to resident goal? Yes No

Duration of relief: _____

Duration of relief: _____

Non-pharmacological interventions and effectiveness.

Non-pharmacological interventions and effectiveness.

Aggravating factors:

Aggravating factors:

Alleviating factors:

Alleviating factors:

*Perform comprehensive pain assessment, being sure to use appropriate pain scale if resident is cognitively impaired

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Resident: _____

Date: _____

Adverse reactions to medication/treatment:

- | | | | |
|---------------------------------------|------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Confusion | <input type="checkbox"/> Pruritis | <input type="checkbox"/> None |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Agitation | <input type="checkbox"/> Rash | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Lethargy | <input type="checkbox"/> Urinary retention | |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Falls | <input type="checkbox"/> Headache | |

Comments: _____

Pain Medication/Treatment Orders

Change: Strength Dosage Route Frequency of current medication to: _____

Change medication to:

Name of Medication _____ Strength _____ Dosage _____

Route _____ Frequency _____

Name of Medication _____ Strength _____ Dosage _____

Route _____ Frequency _____

Name of Medication _____ Strength _____ Dosage _____

Route _____ Frequency _____

Continue medication as currently prescribed

Consults _____

Other _____

Note: All patients on ATC opioids should be started on prophylactic bowel medications to prevent constipation.

Nursing Signature _____

Floor/Unit _____

MD Signature _____

Date _____

Print name _____