Brandon Claflin, DO
Board Certified, Physical Medicine & Rehabilitation
Pain Medicine

Oklahoma Interventional Spine & Pain

Okspinepain.com

Interventional Pain Management, Spine Pain, Musculoskeletal Medicine, Electrodiagnosis (EMG/NCS), Botox

OFFICE POLICIES

- New patients will need to arrive to our office at least 15 minutes prior to your appointment. This allows time for paperwork and insurance updates.
- If you are **more than 5 minutes late** for your appointment, YOU MAY BE RESCHEDULED to the next available appointment and may be charged a **$125.00 late fee.**
- If you are unable to keep your appointment for any reason, please call our office **24 hours in advance** to avoid a rescheduling fee. If you do not show up to or you fail to cancel your appointment 24 hours in advance, you will be charged a **$150.00 "no-show" fee.** This will be billed to the patient, not your insurance company and you will not be rescheduled until this fee is paid.
- Please note **2 appointments** missed without cancelling (these do not need to be consecutive) will result in discharge from our care.
- It is the **patient's responsibility** to verify that we are a participating provider with his/her insurance plan and to understand his/her benefits.
- You will need to present your insurance card/s and photo ID at your initial visit (failure to have either will result in rescheduling once you have those documents available) and at the beginning of each new year and at each renewal or change of insurance. NO balances will be carried.
- **INSURANCE COPAYS MUST BE PAID AT THE TIME SERVICES ARE RENDERED.**

IF YOU ARE PRESCRIBED NARCOTICS:

- You must be seen monthly for refills. You must bring those medications to each office visit in the most recent pill bottle prescribed. Only bring medications prescribed by Dr. Claflin.
- Refill requests must be made **at least 72 hours** prior to running out of medication. This gives us enough time to refill your medication in a timely manner.
- We **DO NOT** replace lost or stolen meds for any reason, even with a police report.
- You will need to sign a medication contract with our office.

I have read and understand the policies listed above.

Patient Signature _____

Tulsa: *9308 S. Toledo Ave * Tulsa, OK 74137 * Phone 918-728-8020 * Fax 918-728-8019*
Bartlesville *421 E 5TH St * Bartlesville, OK 74003 * Phone 918-728-8020 * Fax 918-728-8019*
Stillwater: *801 S Walnut * Stillwater, OK 74074 * Phone 918-728-8020 * Fax 918-728-8019*

PATIENT INFORMATION

Name_____ Date of Birth_____

Address_____

City_____ State_____ Zip Code_____ Home phone_____

Work phone_____ Cell/other_____ Email_____

Social Security Number:_____

What is your preferred method of contact? Home phone Work phone Cell phone Email

Marital status (circle one) Single Married Separated Divorced Widowed

Race (circle one) American Indian Alaskan Native Asian Black Caucasian Other

Ethnicity (circle one) Hispanic Non-Hispanic Primary language:_____

Current employer_____ Phone #_____

Preferred pharmacy (Name/Address/Phone #)_____

Responsible Party (if other than above) _____

Address_____

City_____ State_____ Zip Code_____

Home phone_____ Work phone_____

INSURANCE INFORMATION (if this is a WORKERS COMPENSATION injury, please see the next page)

Do you have medical insurance? Yes / No Is this a workers compensation injury? Yes / No

Insurance (1)_____

Policy #_____ Group # _____

Name on policy_____ DOB_____ SSN_____

Insurance (2)_____

Policy #_____ Group # _____

Name on policy_____ DOB_____ SSN_____

SPOUSE INFORMATION (for emergency contact)

Spouses Name_____ DOB_____ SSN_____

Work phone _____ Cell phone_____

Who would we contact in case of an emergency *other* than your spouse?

Name_____

Work phone_____ Cell phone_____

This is an authorization of release of medical information and payment of medical benefits. I authorize the release of any medical information necessary to process this claim. Also, I request payment of medical benefits to the physician for service. I understand and agree that charges by Oklahoma Interventional Spine & Pain are to be paid in full, and I am responsible for the service and/or items not covered by my insurance company.

Signed_____ Date_____

WORKERS COMPENSATION INFORMATION

Is the reason for the visit a work-related injury? Yes_____(answer questions below) No_____(go to page 4)

Date of injury_____

Body part injured:_____

Workers Compensation Insurance_____

Employer_____Contact_____

Address_____City_____State_____Zip_____

Name of adjuster or case manager (if known)_____

Adjuster or case manager phone_____

Claim Number_____

HEALTH HISTORY

Name:_____ DOB:_____

Age:_____ Height:_____ Weight:_____ Sex: Male / Female

MEDICATIONS:

Please list all ***current*** medications, dose, and how often you take each medicine (if you need more space please write on the back of this paper)

Medication	Dose	How often?

ALLERGIES:

Have you ever had an allergic reaction to:

- Xray dye? Yes / No
- Morphine, Demerol or other narcotics? Yes / No
- Novocain or other anesthetics? Yes / No
- Aspirin or other pain remedies? Yes / No

Please list all allergies, including allergies to medicines.

Medication/Allergy	Type of reaction

SURGERIES:

Do you have any metal in your body from any previous surgeries? Yes / No

Please list previous surgeries

Surgery	Date	Details

SOCIAL HISTORY:

a. Use of alcohol? Never Rarely Moderate Daily
b. Use of tobacco? Never Previously, but quit (When?_____) Active (___packs/day x ___years)
c. Use of recreational drugs (ie Marijuana)? None Some (Type/Frequency_____)
d. Have you ever had a problem with dependency or abuse of prescription or non-prescription drugs? Y / N
   If yes, please explain_____
e. Have you ever been physically abused? Yes / No
f. Have you ever been sexually abused? Yes / No

PAST MEDICAL HISTORY:

Please list ALL conditions you have had in the past

Condition	Age Diagnosed	Details

FAMILY MEDICAL HISTORY:

Please indicate blood relative with any illnesses or pain problems

Family Member	Age	Diseases/pain problems

DIAGNOSTIC STUDIES:

Please list all diagnostic studies you have had done. These can include x-rays, CT scans, MRIs, discograms, EMG/nerve conduction studies, etc.

Study (ex: MRI)	Body part	Date	Location (ex: St Francis)

REVIEW OF SYSTEMS:

Please mark the box next to the u have a history of or currently have:

Constitutional Symptoms:

- ☐ Unexplained weight loss
- ☐ Fever
- ☐ Night sweats

Integumentary:

- ☐ Change in skin color, hair, or nails
- ☐ Change in temperature of extremities
- ☐ Itching

Eyes:

- ☐ Eye disease or injury
- ☐ Wear glasses/contact lenses
- ☐ Blurred vision
- ☐ Glaucoma

Ear/Nose/Mouth/Throat:

- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Dry mouth
- ☐ Chronic sinus problem or rhinitis

Cardiovascular:

- ☐ Heart trouble
- ☐ Chest pain or angina pectoris
- ☐ Palpitations/murmurs
- ☐ Fainting
- ☐ Swelling of feet, ankles, or hands

Respiratory:

- ☐ Chronic or frequent coughs
- ☐ Shortness of breath

Gastrointestinal:

- ☐ Nausea or vomiting
- ☐ Frequent diarrhea
- ☐ Constipation
- ☐ Rectal bleeding or blood in stool
- ☐ Abdominal pain
- ☐ Peptic ulcer (stomach or duodenal)

Hematologic/Lymphatic:

- ☐ Slow to heal after cuts
- ☐ Bleeding or bruising tendency

Musculoskeletal:

- ☐ Joint pain
- ☐ Joint stiffness and/or swelling
- ☐ Weakness of muscles or joints
- ☐ Muscle pain
- ☐ Difficulty in walking

Genitourinary:

- ☐ Frequent urination
- ☐ Bowel/Bladder incontinence

Neurological:

- ☐ Progressive focal weakness
- ☐ Numbness in groin
- ☐ Numbness and/or tingling sensations

Psychiatric:

- ☐ Memory loss or confusion
- ☐ Anxiety
- ☐ Insomnia
- ☐ Depression

Endocrine:

- ☐ Heat or cold intolerance
- ☐ Kidney stones or disease
- ☐ Osteoporosis or vertebral fracture
- ☐ Long term steroid use
- ☐ History of IV drug use

PAIN HISTORY/INVENTORY

If you are NOT seeing us today for PAIN, please skip this section

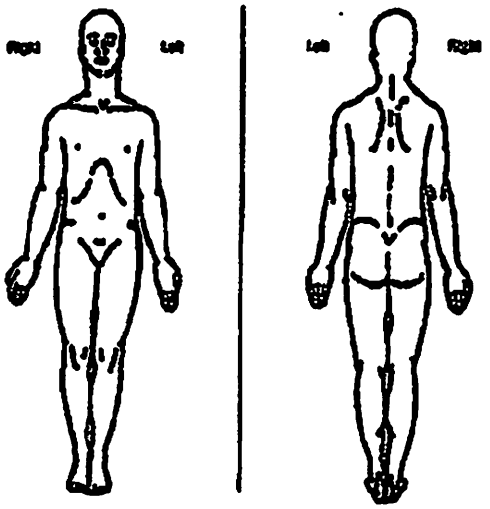
DATE:_____

PATIENT NAME:_____ DOB:_____

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today? (CIRCLE ONE) Yes No

   A. When did your pain begin?_____
   B. What were the circumstances?
      a. Accident (home, work, etc)? Following illness or injury? Pain just began? Explain_____

2. On the diagram, shade in areas where you feel pain. Put an X on the area that hurts the most.



A. Do you have any numbness in your arms or legs?	Yes	No	If yes, where?_____
B. Do you have any tingling sensations in your arms or legs?	Yes	No	If yes, where?_____
C. Do you have any weakness in your arms or legs?	Yes	No	If yes, where?_____
D. Do you have incontinence (loss of control) of bowel?	Yes	No	
E. Do you have incontinence of bladder?	Yes	No	

3. How would you describe your pain (burning, aching, sharp, shooting, electrical, tight, "Charlie horse", etc)?

_____

_____

4. Your pain is (circle one): Constant Constant but intensity varies Intermittent

5. Does the severity of your pain vary according to time of day? Yes No
   If yes, how (worse upon awakening, worse as day goes on, etc)? _____

_____

6. List specific activities or things which ***increase*** your pain:_____

_____

7. List specific activities or things which ***decrease*** your pain:_____

_____

8. Please rate your pain by circling the number that best describes your pain at its ***worst*** in the last 24 hours?

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

9. Please rate your pain by circling the number that best describes your pain at its ***least*** in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

10. Please rate your pain by circling the number that best describes your pain ***on the average***.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

11. Please rate your pain by circling the number that tells how much pain you have ***right now***.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

12. Circle the number that describes how, ***during the past 24 hours***, pain has interfered with your:

A. General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

C. Walking ability

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

D. Normal Work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

14. Have you seen any other physicians for your pain (besides your primary physician)? Yes / No

	Name of Doctor	Treatment Received	Helpful?	Side effects?
Anesthesiologist				
Chiropractor				
Neurologist				
Neurosurgeon				
Pain mgmt. Physician				
Physical Therapist				
Psychologist				
Rheumatologist				
Other				

15. What treatments/therapies have you tried in the ***past*** (that you are ***NOT*** currently using)? These can include heat, TENS unit, physical therapy, massage, injections, etc.

Treatment/Therapy	Helpful? Yes/No	Side effects/why discontinued

16. What treatments/therapies are you ***currently*** using? These can include heat, TENS unit, physical therapy, massage, injections, etc.

Treatment/Therapy	Dose	Frequency

17. Do you or anyone in your family have a history of alcohol or drug addiction? Please explain._____

18. Please briefly describe your goals of treatment:_____

PRIVACY NOTICE

Dear Patient or Representative:

We are committed to protecting the privacy of your medical information. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. This Notice describes your rights and our legal duties regarding your Protected Health Information (PHI). Protected Health Information means any information about you that identifies you or for which there is a reasonable basis to believe the information can be used to identify you.

HOW OKLAHOMA INTERVENTIONAL SPINE & PAIN MAY USE OR DISCLOSE YOUR MEDICAL INFORMATION:

1. We will use your medical information to treat you. For example, if there is any follow-up care such as home health services, etc. We may also disclose your medical information to people outside our office that are involved in your care such as your family members, referring physicians, pharmacist, etc.
2. We may use and disclose your medical information to receive payment for our services from you, and insurance company or a third party. For example, we may need to give your health plan information about a procedure we perform at our office so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether you plan will cover the treatment.
3. We may share your medical information with our business associates. We have a written contract with each business associate that contains terms requiring them to protect the confidentiality of your medical information.
4. Any other uses and/or disclosures of your medical information will be made only with authorization. Your authorization may be revoked, but must be communicated in writing.

DESCRIPTION OF YOUR MEDICAL INFORMATION RIGHTS:

1. You have the right to inspect and copy medical and billing records that we maintain. You must submit your request in writing. By Oklahoma statute, we currently charge $1.00 for the first page and $0.50 each additional page plus postage costs.
2. You have the right to request an amendment to the medical information we have about you if you believe it is incomplete or incorrect. To request an amendment, your request must be made in writing; include a reason for your request, and it will be submitted to the privacy officer. We may deny your request for an amendment for the following reasons: it is not in writing; does not include a reason; the information was not created by us; is not a part of the medical information kept by our practice; is not part of the information which you are permitted to inspect a copy; or in our judgment, the information will be acted on no later than sixty days after its receipt.
3. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, we will only contact you at work, home, by mail, phone, answering machine, etc. Your request must be specific and in writing to the privacy officer in our office.
4. You have the right to request a list of the disclosures we have made of your medical information. To request this list, you must submit your request in writing to this office. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request must state a time period no longer than six years. The first copy of the list is free, but each additional request may invoke a fee.
5. You have the right to request a restriction on the information we use or disclose for treatment, payment, or health care. Information for treatment or health care operations we are not required to agree to the restriction and reserve the right to immediately withdraw our services from you and terminate the relationship.
6. You have the right to receive a paper copy of this Privacy Notice.

For more information or to report a problem you may contact the Oklahoma Interventional Spine & Pain Privacy Office, 9308 S Toledo Avenue, Tulsa, OK 74137. If you believe your privacy rights have been violated, you may file a complaint with the Privacy officer or the Secretary of the Department of Health and Human Services. All complaints must be in writing. There will be no retaliation by Oklahoma Interventional Spine & Pain if you file a complaint.

We reserve the right to change or amend this Privacy Notice at any time in the future. Revised copies will be available to you.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

Oklahoma Interventional Spine & Pain

9308 S. Toledo Avenue

Tulsa, OK 74137

918-728-8020

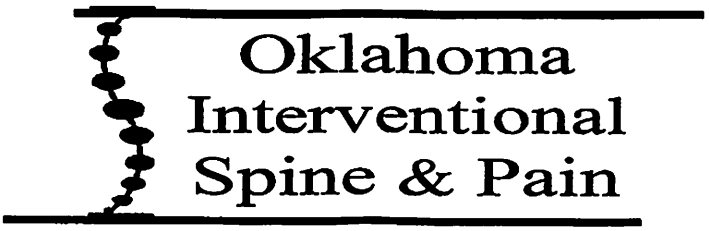
A complete description of how your medical information will be used and disclosed by Oklahoma Interventional Spine & Pain is in our "Privacy Notice", which you should read before signing this acknowledgment.

I hereby certify that I have read the "Privacy Notice" for "Oklahoma Interventional Spine & Pain".

_____ _____

Patient or representative Date signed

Brandon Claflin D.O
Board Certified, Physical Medicine & Rehabilitation Medicine



Okspinepain.com

interventional Spine Pain Management. Electrodiagnosis (EMG, Nerve Conduction Studies), Workers Compensation Injuries

HIPAA RELEASE OF PROTECTED HEALTH INFORMATION

Patient Signature._____Date:_____

Please provide us with a list of names of whom you would allow our office to release OR discuss medical information.

Information may be released to the following individuals:

Name:_____ Relationship to patient._____

Name:_____ Relationship to patient._____

Name:_____ Relationship to patient_____

Tulsa: 9308 S. Toledo Ave Tulsa, OK 74137 •918.728.8020 • Fax 918.728.8019
Bartlesville: 421 E. 5th St. Bartlesville, OK 74003 • 918.728.8020 • Fax 918.728.8019
Stillwater: 801 S. Walnut St. Stillwater, OK 74074 • 918.728.8020 • Fax 918.728.8019

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MEDICATION CONTRACT

Our goal is to provide you the best care possible. For that reason, we have designed a medication contract to help you understand our policies, provide with you the highest quality health care available and avoid confrontations.

Please read this Information carefully. If you have questions about your medication or this policy ask the providers or staff. Once you understand this in information fully, please sign and date below, indicating your pledge to help us provide you with the highest medical care. A copy of this pain contract will be sent to your primary care physician to assist him/her to provide you the optimum care and to allow the coordination of your pain medication.

MEDICATIONS CAN HAVE SIDE EFFECTS

You may be prescribed medication in an effort to treat your illness or relieve your discomfort. A medication will not be prescribed unless it is likely to be beneficial. Fortunately, most medicines help patients without any signification side effects. Any medicine can have side effects in some patients, and some of them can be serious or even life threatening. You will be informed of many of the common possible side effects. However, no one can list all the possible side effect that can occur with a medicine, but every effort will be made to inform you of the common side effects. Medications should **not** be combined with the consumption of alcohol. Combining Opiates with Benzodiazepines will **NOT** be acceptable due to overdose risk.

PAIN MEDICATION CAN BE ADDICTIVE OR TOLERANCE MAY OCCUR

You may receive prescriptions for narcotic pain medications, which can be addicting, or tolerance may develop. Tolerance can cause loss of pain reduction of the pain medication and it takes more medication to achieve the same relief. The medication Is only indicated to increase your function, improve the quality of your life and improve pain control. The goal of pain medication is to allow you to participate in activities of daily living, remain in the work force, engage in activities that you find enjoyable, and allow you to take part in exercise or therapy programs. Because these drugs have potential for abuse or diversion, strict accountability Is necessary when use is prolonged. For this reason, the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1) All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to unwanted drug interactions or poor condition of treatment.)
2) I understand that Dr. Claflin will no longer prescribe medication should I be found to be misusing the medication in **any way.**
3) I will obtain prescriptions for pain medication only from Dr. Claflin and take the medication as prescribed. If I violate this, my narcotic prescription will be tapered and stopped.
4) You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

6) Any prescription or medication that is lost, misplaced, get wet, are destroyed, left on an airplane, stolen, etc will not be replaced. There will be no exceptions on this policy.
7) Medication is to be taken as prescribed and will not be filled early for any reason. Medication must be taken as prescribed.
8) I will not share, sell or otherwise permit others to have access to these medications. Not only it is a violation of Federal law, it could be dangerous.
9) If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
10) These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop. I agree to taper and wean the medication when appropriate.
11) In order to have your medication refills you must have a follow-up appointment routinely. Dosage adjustment and a change in status may require you to be seen more frequently.
12) Unannounced urine or serum toxicology (blood) screens may be requested, and your cooperation is mandatory. Presence of unauthorized substances may prompt referral for assessment and addictive disorder.
13) Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.
14) Original containers of medications should be brought in to each visit.
15) I understand that if any prescription is changed or tampered with in any way the Drug Enforcement Department of the Tulsa Police Department will be notified.
16) I will attempt to obtain my medication from a single pharmacy.
17) It is my responsibility to monitor my medication and to request refills in the following manner:
    A. Call your pharmacy to request a refill of your medications. Do not call the office; the pharmacist will contact us and we will notify you when it is ready to pick up.
    B. Certain pain medications require monthly written prescriptions. These can be obtained by coming to the office.
    C. All prescriptions require 72 hours to be refilled.
    D. DO NOT CALL FOR PRESCRIPTIONS AFTER HOURS OR ON WEEKENDS
18) It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.
19) It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.
20) You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

Refills will be made only during the follow hours: Monday through Thursday 8:00am to 5:00pm and Friday 8:00am to 12:00pm. Medication will only be refilled during the hours listed above and will not be refilled on the weekend.

*** Bring in old bottles if we need to change Rx or if you are developing an allergy or tolerance to the medication.

Patient Signature _____ Date _____

Physician Signature _____ Date _____

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Consent for Chronic Opioid Therapy

Dr. Claflin is prescribing opioid medicine, sometimes called narcotic analgesics, to me for a diagnosis of _____This decision was made because my condition Is serious or other treatments have not helped my pain.

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to sleepiness or drowsiness, constipation, nausea, Itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed included._____

I will tell my doctor about all other medicines and treatments that I am receiving.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include but are not limited to: using heavy equipment or a motor vehicle. working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

I am aware that certain other medicines such as nalbuphine (Nubain TM), pentazocine (TalwinTM), buprenorphine (BuprenexTM), and butorphanol (StadolTM), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine Is very low. I am aware that the development of addiction has been reported rarely in medical Journals and is much more common in a person who has a family or personal history OI addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

J understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use Is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose. yawning. large pupils. goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to being big problem for mos.t patients with chronic pain, however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

(Males Only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

(Females Only) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medications, the baby will be physically dependent on opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medications and there is always the possibility that my child will have a birth defect while I am taking an opioid.

I have read this form, or it has been read to me and I understand all of it. I have had a chance to have all my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medications.

Patient signature_____Date_____

Physician signature_____Date_____

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Rapid Opioid Dependence Screen (RODS)

PATIENT NAME_____ **DATE**_____

1. Have you ever taken any of the following drugs?
   a. Heroin Yes No
   b. Methadone Yes No
   c. Buprenorphine Yes No
   d. Morphine Yes No
   e. MS Contin Yes No
   f. Oxycontin Yes No
   g. Oxycodone Yes No
   h. Other Opioid analgesics (Ex: Norco, Darvocet, etc.) Yes No

If any drug in question 1 is coded "Yes" proceed to questions 2 -8

2. Did you ever need to use more opioids to get the same high as when you started Yes No
3. Did the idea of missing a fix (or dose) ever make you anxious or worried Yes No
4. In the morning did you ever use opioids to keep from feeling "dope sick" or did you ever feel "dope sick"? Yes No
5. Did you worry about your use of opioids? Yes No
6. Did you find it difficult to stop or not use opioids? Yes No
7. Did you ever need to spend a lot of time or energy on finding opioids or Recovering from feeling high? Yes No
8. Did you ever miss important things like doctor's appointments, family/ friend activities or other things because of opioids? Yes No

**********DR. ONLY BELOW THIS LINE**********

Opioid Dependent:

YES or NO