WNY Rehab and Pain Management

Su Zhan, MD, PhD

Note to the patient:

If your insurance requires a referral from your Primary Physician to see Dr. Zhan, who is a Specialist, it is the responsibility of the patient to get the referral from their Primary Doctor before the scheduled appointment or we may have to reschedule your appointment.

To be assured your visit is covered by your insurance for Dr. Zhan, please contact your insurance company in advance to verify if a referral is needed.

YOU MUST HAVE A PRIMARY PHYSICIAN. DR. ZHAN CANNOT BE YOUR PRIMARY PHYSICIAN.

Bring your insurance card and picture ID.

ALL CO PAYS ARE DUE AT THE TIME OF EACH VISIT.

WE ACCEPT CASH, DEBIT AND CREDIT CARDS ONLY.

Your Primary Doctor's office may fax your referral to us, along with a demographic sheet and medication list.

As always, thank you for your understanding.

100 Union Rd, West Seneca, NY, 14224; Office: 716-677-2700; Fax: 716-677-2733

Su Zhan, MD PhD
WNY Rehabilitation Medicine and Pain Management

Registration Form

NAME_____ DATE OF BIRTH_____

STREET ADDRESS_____

CITY_____ STATE_____ ZIP_____

SSN_____ PHONE NUMBER_____

SEX MALE /FEMALE CELL NUMBER_____

PLACE OF EMPLOYMENT_____

ADDRESS_____ CITY_____

STATE_____ ZIP_____PHONE_____

NAME OF INSURANCE_____ EFFECTIVE DATE_____

ID NUMBER_____ GROUP_____

NAME OF INSURED IF DIFFERENT FROM PATIENT_____

PHONE_____

SECONDARY INSURANCE_____EFFECTIVE DATE_____

ID NUMBER_____ GROUP_____

PHONE_____

AUTO ACCIDENT DATE OF INJURY_____ POLICY #_____

NAME AND ADDRESS OF CARRIER_____

CLAIM #_____ PHONE _____

DATE OF ACCIDENT_____ NAME OF INSURED IF DIFFERENT _____

COMPENSATION WCB#_____ CARRIER CASE #_____

DATE OF INJURY_____ NAME OF INSURANCE_____

ADDRESS OF INSURANCE_____STATE_____ ZIP_____

PHONE_____SPECIFY BODY PART_____

REFERRING DOCTOR_____ PHONE_____

PRIMARY DOCTOR _____ PHONE_____

ADDRESS AND CITY_____ ZIP_____

I authorize release of medical information necessary to process this claim and all future claims, and request that payment of medical benefits be made directly to **Dr. Su Zhan,** the physician who rendered services to me.
I authorize you to bill my Medigap insurance and request that payment be made to **Dr. Su Zhan.**

PATIENTS SIGNATURE _____ DATE_____

UPDATED MEDICATION LIST:

Patient Name:

Patient DOB:

Date:

Medication:

Dosage:

Medication:

Dosage:

Medication:

Dosage:

Medication:

Dosage:

Medication:

Dosage:

Medication:

Dosage:

Medication:

Dosage:

Medication:

Dosage:

Medication:

Dosage:

If you have more medication, please place it on the back of this form

APPENDIX F: PATIENT INFORMED CONSENT FOR OPIOID TREATMENT FORM

PATIENT INFORMED CONSENT FOR OPIOID TREATMENT FORM

Patient Name: WCB Claim #:

Doctor Name: Dr. Sa Zhan

I plan to take a pain medicine called OPIOIDS. This pain medicine may help improve my pain but it may also cause some serious problems. The problems may be worse if I mix the pain medicine with alcohol or other drugs.

I understand that the pain medicine I will be taking may cause serious problems including:

- ⇨ Confusion.
- ⇨ Poor judgment.
- ⇨ Nausea (a stomach ache).
- ⇨ Vomiting.
- ⇨ Constipation (hard stools that may be painful to push out).
- ⇨ Sleepy or drowsy feeling.
- ⇨ Poor coordination and balance (such as feeling unsteady, tripping, and falling).
- ⇨ Slow reaction time.
- ⇨ Slow breathing or I can stop breathing - which could cause me to die.
- ⇨ More depression (such as feeling sad, hopeless, or unable to do anything).
- ⇨ Dry mouth.
- ⇨ Increased feeling of pain (hyperalgesia).
- ⇨ Addiction (it may be very hard to stop taking the pain medicine when I'm ready to quit).
- ⇨ For men: the pain medicine may lead to less interest in sex and poor sexual performance.
- ⇨ For pregnant women, the pain medicine may hurt my unborn child and may cause my child to be born addicted to the pain medicine.

I will tell my doctor if I have any of the problems listed here.
I understand there may be other problems caused by the pain medicine, in addition to the problems listed here.
I understand that these problems may get better when I stop taking the pain medicine.
My doctor has reviewed the serious problems that this pain medicine may cause. My doctor has answered all questions that I have about this pain medicine and the serious problems it may cause.

Patient Signature: Date:

I attest that this form was reviewed by me with the patient and all questions were answered.

Doctor Signature: Date:

APPENDIX G: PATIENT UNDERSTANDING FOR OPIOID TREATMENT FORM

PATIENT UNDERSTANDING FOR OPIOID TREATMENT FORM

Patient Name _____ WCB Claim #: _____

Doctor Name Dr Su Zhao

I am taking a pain medicine called **OPIOIDS** to help improve my pain.

I agree (the *patient must initial each box to show agreement):*

- ☐ I will take my pain medicine exactly the way my doctor tells me to. That means I will take the right amount of pain medicine at the right time.
- ☐ I will tell my doctor about any new medical problems.
- ☐ I will tell my doctor about all medicine I take, and will tell my doctor if I am given any new medicines.
- ☐ I will tell my doctor if I see another doctor, or if I go to the Emergency Room.
- ☐ I will only get my pain medicine prescription from this doctor. My doctor's name is listed on the top of this page.
- ☐ If my doctor is away, I will only get medicine from the doctor who is in charge while my doctor is away.
- ☐ I will only get my pain medicine from one pharmacy (drug store).
- ☐ I will follow my doctor's directions about therapy, exercises and physical things to do so I can learn to live with my pain.
- ☐ I will do what I can to get back to work.
- ☐ I will not drink alcohol or use any other drugs unless I am told to do it by my doctor.
- ☐ When I am asked, I will get lab tests to see if I am taking my medicines the right way.
- ☐ If the lab tests show that I am not taking the medicines the way I should, my doctor may cut down or stop my medicine or send me to a specialist or special program to help care for me.
- ☐ I will store my pain medicine in a safe place where other people cannot take it.
- ☐ I will keep my scheduled appointments. If I must miss an appointment, I will call my doctor to cancel at least 24 hours before the appointment.
- ☐ My doctor may stop giving me pain medicine if:
  - I do not follow this agreement.
  - The pain medicine is not helping me.
  - I'm not meeting my goals in active therapy.
  - My pain or my functions do not improve.
  - I have bad side effects from the pain medicine.
  - I become addicted to the pain medicine.
  - I give or sell the pain medicine to someone else.
- ☐ I am not pregnant and I will call my doctor as soon as possible if I think I may be pregnant.

Patient Signature: Date:

I attest that this form was reviewed by me with the patient and all questions were answered.

WNY Rehab Medicine & Pain Mgmt
Su Zhan, MD, PhD
100 Union Rd
West Seneca, NY 14224

(Patient to complete this form)

INITIAL PATIENT CONSULT

Name:_____
Date:_____ Age:_____
Sex: M F Handedness: R L
D.O.B._____ Referred by:_____

FUNCTIONAL GOAL (What activity do you want to do after this program that you are not able to do now due to pain?)

_____
_____
_____

CHIEF COMPLAINT:

☐ Neck Pain	R	L	☐ Upper Back Pain	R	L
☐ Shoulder Pain	R	L	☐ Mid Back Pain	R	L
☐ Elbow Pain	R	L	☐ Lower Back Pain	R	L
☐ Wrist Pain	R	L	☐ Hip Pain	R	L
☐ Hand Pain	R	L	☐ Knee Pain	R	L
			☐ Ankle Pain	R	L

Others:_____
_____
_____
Date of Injury/Illness:_____
Nature of Injury/Illness (describe how it happened)_____
_____
_____
_____
Radiation to (body part):_____
☐Numbness & Tingling ☐Hands ☐L ☐R ☐Both
☐Feet ☐L ☐R ☐Both

☐Immediate Pain ☐Gradual over____days
☐Gradual over___months ☐Gradual over___years
Quality: ☐Stabbing ☐Sharp ☐Throbbing
☐Burning ☐Electrical ☐Shooting
☐Aching ☐Sore ☐Dull
☐Others_____
Frequency: ☐Constant ☐Frequent ☐Intermittent ☐Rare
Accompanying symptoms
☐Yes:_____
☐No
Seen other Doctors other than your current physician?
☐Yes ☐just one ☐2-3 ☐4-5 ☐>5
Names of Doctors (if remembered)
_____
_____
_____
☐No, just being seen by my current physician
Does the pain disturb your:
☐Sleep ☐Walking ☐Concentration ☐Relationships
☐Eating ☐Housework ☐Energy ☐Enjoyment in life
☐Selfcare ☐Work ☐Mood ☐Recreation
How often do you use the following:

Walker	☐Never	☐Sometimes	☐Usually/Often
Cane	☐Never	☐Sometimes	☐Usually/Often
Wheel chair	☐Never	☐Sometimes	☐Usually/Often
Crutches	☐Never	☐Sometimes	☐Usually/Often
Neck collar	☐Never	☐Sometimes	☐Usually/Often

(None) → (worst)
Pain Intensity today 0 1 2 3 4 5 6 7 8 9 10
Avg pain past 7 days 0 1 2 3 4 5 6 7 8 9 10

	Pain↑	Pain↓	No Change
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Bending	☐	☐	☐
Lying down	☐	☐	☐
Sexual activity	☐	☐	☐
Worry/Stress	☐	☐	☐

Functional Limitations(Indicate # minutes you tolerate):
Sitting:_____min Walking:___min
Standing:____min Others:_____min
Previous Injury/ies (date & nature):
_____
_____
_____
Allergies:_____
Past Illnesses & Hospitalizations:_____
_____
_____
_____
Pregnant ☐Yes ☐No ☐Not Applicable
Family History of diseases/illnesses:
_____
_____
_____

PsychoSocial:
Status ☐Married ☐Single ☐Widow(er)
Living with ☐self ☐spouse ☐family ☐others
Substance Use:
☐Alcohol ☐daily ☐weekly ☐occ'ly ☐never
☐Smoking ☐Yes ☐No _____
☐Illicit Drug ☐Yes ☐No _____
Depression:
☐Decreased sleep ☐Fatigue
☐Feelings of Guilt ☐Decreased Interest
☐Impaired Concentration ☐Decreased Appetite
☐Suicidal Thoughts
Employment Status:
☐Full Time ☐Part Time
☐Temporarily Disabled ☐Permanently Disabled
☐Unemployed ☐ Retired
If disabled, date last worked:_____
If disabled, have you tried to return to work? ☐Yes☐No
Do you think you can return to your regular job?
☐Yes ☐No
Brief description of your usual job:_____
_____
If your pain was controlled, would you plan to go back to work? ☐Full Time ☐Part Time ☐Not at all
Educational History: Highest level of education
☐some elementary school ☐finished elementary sch
☐High school undergrad ☐High school graduate
☐Some college ☐College/Post graduate

INITIAL PATIENT CONSULT

Mark on the Diagram:

X – point of maximum pain/origin
O – where the pain ends

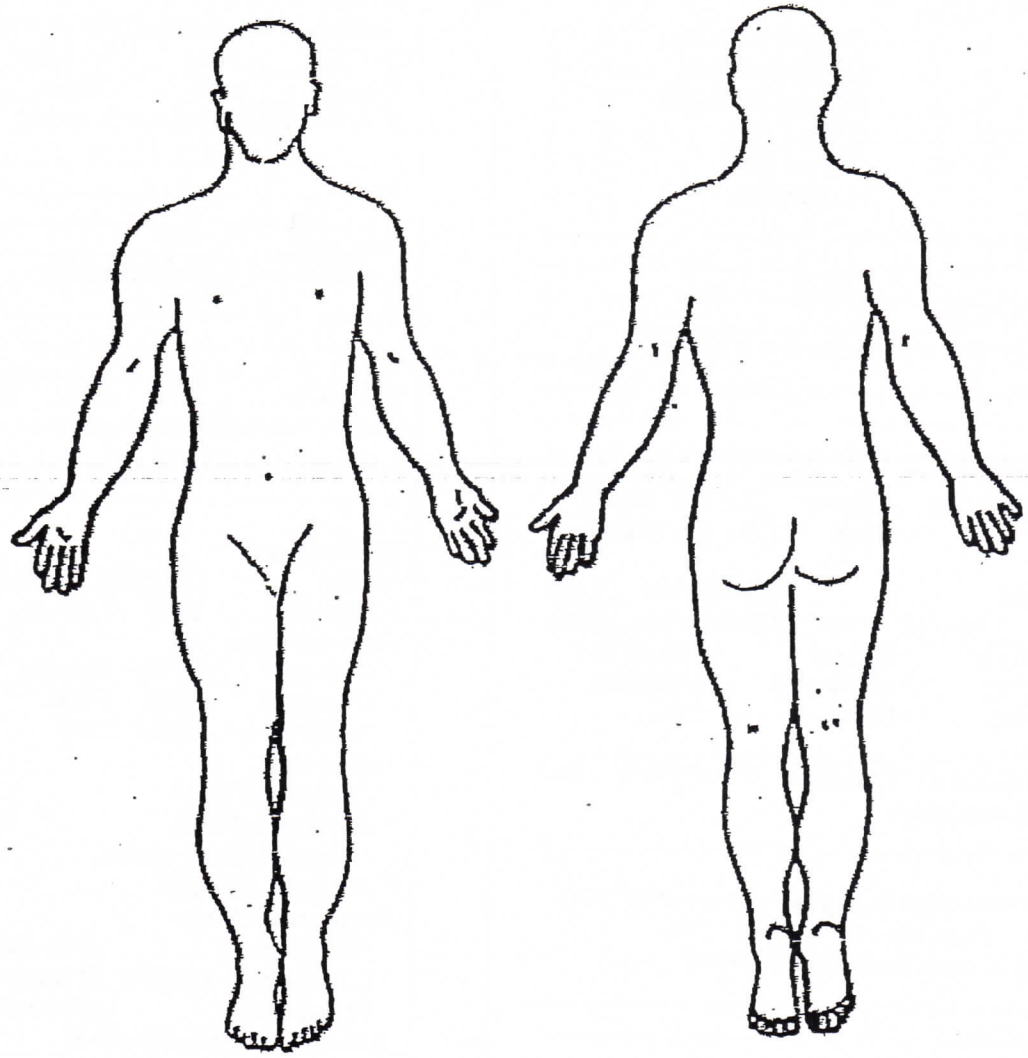
→ - direction of pain

PAIN DRAWING

Draw the location of your pain on the body outlines.

FRONT

BACK



Patient Name:_____

INITIAL PATIENT CONSULT

Medications used in the past:

☐Anti inflammatory ☐Helped ☐Not Helped

_____

☐Muscle relaxant ☐Helped ☐Not Helped

_____

☐Pain medications ☐Helped ☐Not Helped

☐Non Narcotic ☐Helped ☐Not Helped

_____

☐Narcotic ☐Helped ☐Not Helped

_____

☐Anti depressants ☐Helped ☐Not Helped

☐Others ☐Helped ☐Not Helped

_____

Current Medications:

☐Anti inflammatory ☐Helped ☐Not Helped

_____

☐Muscle relaxant ☐Helped ☐Not Helped

_____

☐Pain medications ☐Helped ☐Not Helped

☐Non Narcotic ☐Helped ☐Not Helped

_____

☐Narcotic ☐Helped ☐Not Helped

_____

☐Anti depressants ☐Helped ☐Not Helped

☐Others ☐Helped ☐Not Helped

_____

Were these done in the past?

☐Xrays ☐MRI ☐CTscan ☐NCV ☐EMG

Results (if available)_____

_____

_____

Prior Treatments for Pain:

☐Physical Therapy Date_____ ☐Helped ☐No Change

☐Nerve Stimulator (TENS) ☐Helped ☐No Change

☐Ultrasound/Heat packs ☐Helped ☐No Change

☐Acupuncture Date_____ ☐Helped ☐No Change

☐Chiropractic Date_____ ☐Helped ☐No Change

☐Biofeedback/Hypnosis ☐Helped ☐No Change

☐Epidural Injections #_____ ☐Helped ☐No Change

Last injection?_____ ☐Helped ☐No Change

☐Other Injections_____ ☐Helped ☐No Change

_____ ☐Helped ☐No Change

_____ ☐Helped ☐No Change

☐Surgeries

_____date_____ ☐Helped ☐No Change

_____date_____ ☐Helped ☐No Change

_____date_____ ☐Helped ☐No Change

Review or Systems:

☐Fever ☐Weight gain ☐Weight loss

☐Appetite change ☐Dizziness

☐Difficulty breathing ☐Cough ☐Cold

☐Chest pain ☐Palpitations

☐Abdominal Pain ☐Nausea/Vomiting

☐Constipation ☐Diarrhea

☐Bladder changes ☐Sexual dysfunction

☐Headache ☐Loss of consciousness

☐Seizure ☐Memory loss

☐Gait disturbance ☐Rashes ☐Bleeding

Notes

Date _____

Patient Name _____

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Your Parents History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
TOTAL		[ ]		

Total Score Risk Category Low Risk 0 – 3 Moderate Risk 4 – 7 High Risk ≥ 8

Progress Note

Pain Assessment and Documentation Tool (PADT™)

Patient Name: _____ Record #: _____

Assessment Date: _____

Patient Stamp Here

Current Analgesic Regimen

Drug Name	Strength (eg, mg)	Frequency	Maximum Total Daily Dose

The PADT is a clinician-directed interview; that is, the clinician asks the questions, and the clinician records the responses. The Analgesia, Activities of Daily Living, and Adverse Events sections may be completed by the physician, nurse practitioner, physician assistant, or nurse. The Potential Aberrant Drug-Related Behavior and Assessment sections must be completed by the physician. Ask the patient the questions below, except as noted.

Analgesia

If zero indicates "no pain" and ten indicates "pain as bad as it can be," on a scale of 0 to 10, what is your level of pain for the following questions?

1. What was your pain level on average during the past week? (Please circle the appropriate number)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be

2. What was your pain level at its worst during the past week?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be

3. What percentage of your pain has been relieved during the past week? (Write in a percentage between 0% and 100%.)

_____

4. Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference in your life?

☐ Yes ☐ No

5. Query to clinician: Is the patient's pain relief clinically significant?

☐ Yes ☐ No ☐ Unsure

Activities of Daily Living

Please indicate whether the patient's functioning with the current pain reliever(s) is Better, the Same, or Worse since the patient's last assessment with the PADT.* (Please check the box for Better, Same, or Worse for each item below.)

	Better	Same	Worse
1. Physical functioning	☐	☐	☐
2. Family relationships	☐	☐	☐
3. Social relationships	☐	☐	☐
4. Mood	☐	☐	☐
5. Sleep patterns	☐	☐	☐
6. Overall functioning	☐	☐	☐

*If the patient is receiving his or her first PADT assessment, the clinician should compare the patient's functional status with other reports from the last office visit.

(Continued on reverse side)

6a

Progress Note

Pain Assessment and Documentation Tool (PADT™)

Adverse Events

1. Is patient experiencing any side effects from current pain reliever? ☐ Yes ☐ No

Ask patient about potential side effects:

	None	Mild	Moderate	Severe
a. Nausea	☐	☐	☐	☐
b. Vomiting	☐	☐	☐	☐
c. Constipation	☐	☐	☐	☐
d. Itching	☐	☐	☐	☐
e. Mental cloudiness	☐	☐	☐	☐
f. Sweating	☐	☐	☐	☐
g. Fatigue	☐	☐	☐	☐
h. Drowsiness	☐	☐	☐	☐
i. Other_____		☐	☐	☐
j. Other_____		☐	☐	☐

Potential Aberrant Drug-Related Behavior

This section must be completed by the physician

Please check any of the following items that you discovered during your interactions with the patient. Please note that some of these are directly observable (eg, appears intoxicated), while others may require more active listening and/or probing. Use the "Assessment" section below to note additional details.

- ☐ Purposeful over-sedation
- ☐ Negative mood change
- ☐ Appears intoxicated
- ☐ Increasingly unkempt or impaired
- ☐ Involvement in car or other accident
- ☐ Requests frequent early renewals
- ☐ Increased dose without authorization
- ☐ Reports lost or stolen prescriptions
- ☐ Attempts to obtain prescriptions from other doctors
- ☐ Changes route of administration
- ☐ Uses pain medication in response to situational stressor
- ☐ Insists on certain medications by name
- ☐ Contact with street drug culture
- ☐ Abusing alcohol or illicit drugs
- ☐ Hoarding (ie, stockpiling) of medication
- ☐ Arrested by police
- ☐ Victim of abuse
- ☐ Other: _____

_____

_____

2. Patients overall severity of side effects?

☐ None ☐ Mild ☐ Moderate ☐ Severe

Assessment: (This section must be completed by the physician.)

Is your overall impression that this patient is benefiting (eg, benefits, such as pain relief, outweigh side effects) from opioid therapy? ☐ Yes ☐ No ☐ Unsure

Comments: _____

_____

Specific Analgesic Plan:

Comments: _____

- ☐ Continue present regimen
- ☐ Adjust dose of present analgesic
- ☐ Switch analgesics
- ☐ Add/Adjust concomitant therapy
- ☐ *Discontinue/taper off opioid therapy*

Date: _____ Physicians Signature: _____

WNY Rehab and Pain Management

Su Zhan, MD, PhD

Consent to treatment

I _____, hereby authorize Dr. Su Zhan to manage my chronic pain by using medications including Opiates.

I am aware that Opioids or Opioid derivatives are the most potent drugs among modern medicine to control the pain. This group of drugs includes oxycodone, hydrocodone, hydromorphone, Oxymorphine, morphine, fentanyl, tapentadol, buprenorphine, propoxyphene, methadone, and codeine. Opioids decrease the perception of pain, and it does not eliminate or reduce the painful stimulus. They induce sleep, insensibility, or stupor.

Symptoms of Opioids or Opioids derivatives overdose include drowsiness, slurred speech, difficulty walking, lethargy, confusion, slow pulse, slow breathing rate, nausea, vomiting, hallucinations, and loss of consciousness. If the dose is large enough, a narcotic overdose can lead to cardiac arrest and death. The predominant cause of Mortality and Morbidity from Opioids is respiratory compromise.Increased incidence of Mortality has been documented in patients with co-existing lung disease such as COPD (bronchitis, empysema) or in smokers. The respiratory effort frequently is impaired due to opiate intoxication. Breathing rates can be as slow as 4-6 breaths per minute (16-20 breathe per minute in normal state) in a state of moderate-to-severe intoxication. Death can occur because of hypoxia.

A majority of Opioids or Opioid derivatives has no ceiling effects for pain control. The higher dose of Opioids or Opioid derivatives are, the less pain perception will be. Although a patient can have above side effects including death by taking any dose of Opioids or Opioid derivatives, patients who are taking a daily total Opioids or Opioid derivatives higher than 100mg equivalent dose of morphine have extreme high risk to develop complications including respiratory failure, loss of consciousness, heart arrest resulting in death.

I, _____, understand the above risks associated with Opioids or Opioid derivatives. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I,_____, consent to the treatments including using Opioids or Opioid derivatives, with fully understanding that the above mentioned medical complications may arise during the course of my treatments.

My signature confirms that the associated risks and benefits by using Opioids or Opioid derivatives has been understood and accepted.

Patient/Health Care Proxy's signature _____; Date _____

Witness signature _____; Date _____

Physician's signature _____; Date _____

WNY Rehab and Pain Management

Su Zhan, MD, PhD

CONSENT FOR TREATMENT WITH OPIOID (NARCOTIC) PAIN MEDICINES

Patient Name:_____ Date:_____

I have tried other medical treatments, which have not worked to control my pain. My physician has recommended that I be placed on a trial of opioids to help manage my pain better and to improve my ability to participate in social and work actives. This is a decision that I have made after fully discussing with my physician the risks and benefits of this treatment, as well as alternatives to this treatment.

RISKS:

I understand that treatment of pain with opioids does have risks, including but not limited to:

1. Constipation
2. Nausea
3. Sleepiness or drowsiness
4. Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles.
5. Confusion or other change in mental state or thinking abilities.
6. Physical dependence – which means that abrupt stopping of the drug may lead to a withdrawal syndrome characterized by one or more of the following:
    - Runny nose
    - Diarrhea
    - Abdominal cramping
    - "Goose flesh" (roughness of the skin – goose pimples)
    - Anxiety
7. Physical dependence also means it is possible that stopping the drug will cause me to miss or crave it.
8. Decreased appetite
9. Problems urinating
10. Sexual dysfunction (difficulty with natural sexual functioning)
11. Risk to unborn children, which include, but are not limited to narcotic dependence.

WNY Rehab and Pain Management

Su Zhan, MD, PhD

I have read this document, understand it, and have had all questions answered satisfactorily.

Patient signature _____ Date:_____

Interpreter's statement: I have translated the information presented orally to the individual concerned. To the best of my knowledge and belief, he/she understood this explanation.

Interpreter's signature:_____

550 Orchard Park Rd, Bldg C, 2nd Fl, West Seneca, NY, 14224; Office: 716-677-2700; Fax: 716-677-2733

Consent for Chronic Opioid Therapy

I understand that Dr. Zhan ("my physician") is recommending opioid medicine, sometimes called narcotic analgesics, to treat my _____.

I understand that this medication is being recommended because my pain complaints are moderate to severe and other treatments have not sufficiently helped my pain. I understand that many medications can have interactions with opioids that can either increase or decrease their effect. Therefore, I have told my physician about all other medicines and treatments that I am receiving – and that I will promptly advise my physician if I start to take any new medications or have new treatments. Likewise, I have told my physician about my complete personal drug history and that of my family.

I have been informed by my physician that the initiation of a narcotic/opioid medication is a trial. Continuation of the medication is based on evidence of benefit to me from, associated side effects of, and compliance with instructions on, usage of the medication. I have also been informed by my physician that continuation and any changes in dosage of the medication will be determined by pain relief, functional improvement, side effects, and adherence to usage restrictions. Lack of significant improvement, the development of adverse side effects, or other considerations may lead my physician to discontinue this treatment or to change dosage.

It has been explained to me that taking narcotic/opioid medication has certain risks associated with it. These include, but are not limited to, the following:

- Allergic reactions
- Overdose (which could result in harm or even death)
- Slowing of breathing rate
- Slowing of reflexes or reaction time
- Sleepiness, drowsiness, dizziness, and/or confusion
- Impaired judgment and inability to operate machines or drive motor vehicles
- Nausea, vomiting, and/or constipation
- Itching
- Physical dependence or tolerance to the pain relieving properties of the medication (This means that if my

medication is stopped, reduced in dose, or rendered less effective by other medications I may be taking, I may experience runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping,

diarrhea, irritability, aches throughout my body, and a flu-like feeling. These can be very painful but are generally not life-threatening.)

- Addiction
- Failure to provide pain relief
- Changes in sexual function (This is generally caused by reduced testosterone levels. Such reduced levels may

affect mood, stamina, sexual desire and physical and sexual performance.) • Changes in hormonal levels

In addition, use of these medications poses special risks to women who are pregnant or may become pregnant. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetrician and this office to inform them. I have been advised that, should I carry a baby to delivery while taking this medication, the baby will be physically dependent upon opioids. I also understand that birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid. Furthermore, I recognize that the long-term consequence on a child's development who was exposed to opioids is not understood.

It has been explained to me that there are other treatments that do not involve use of narcotic/opioid medications.

Having been informed of these risks and potential benefits both of such medications and possible alternative treatments, I have freely consented to taking the narcotic/opioid medication.

I would note that I have been given the opportunity of ask any questions that I may have – and that any questions that I have raised have been discussed to my satisfaction.

I will take this/these medication(s) only as prescribed and I will not change the amount or dosing frequency without authorization from my physician. I understand that unauthorized changes may result in my running out of medications early, and early refills may not be allowed. I also understand that if I do not take the medication correctly, I may have withdrawal reactions that may include stomach pain, sweating, anxiety, nausea, vomiting and general discomfort.

I have been advised by my physician 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. I understand that 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 will obtain all opioids prescriptions from my physician or, during his or her absence, by the covering physician. Requests for pain medications from the on-call physician (nights and weekends) will not be honored. I will not request medications outside of normal business hours.

I will obtain all scheduled medications from one pharmacy. I will notify my physician if I change pharmacies. The pharmacy that I have selected is: _____. Its phone number is: _____

I hereby authorize my physician to discuss all diagnostic and treatment details of my condition with the pharmacists at the dispensing pharmacy.

I will submit to random pill counts and urine and/or blood drug tests as requested by my physician to monitor my treatment. I understand that the presence of any unauthorized substances in my urine or blood may prompt referral for assessment of addiction or chemical dependency and could result in discontinuation of further opioid prescriptions. I also understand that failure to follow these rules may lead to my no longer being treated by my physician after a 30-day, emergency only period.

I will not share, sell or otherwise permit others to have access to these medications.

I HAVE READ THIS FORM OR HAVE HAD IT READ TO ME. I UNDERSTAND ALL OF IT. I HAVE HAD A CHANCE TO HAVE ALL OF 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 MEDICINES.

I UNDERSTAND AND AGREE THAT FAILURE TO ADHERE TO THESE POLICIES WILL BE CONSIDERED NONCOMPLIANCE AND MAY RESULT IN CESSATION OF OPIOID PRESCRIBING BY MY PHYSICIAN AND POSSIBLE DISMISSAL FROM THIS CLINIC.

Patient signature_____ Date_____

Witness to above_____

Physician_____

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We are committed to doing all we can to treat your chronic pain condition. In some cases, controlled substances are used as a therapeutic option in the management of chronic pain and related anxiety and depression, which is strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper controlled substance use. The words "we" and "our" refer to the facility and the words "i", "you", "me", or "my" refer to you, the patient.

1.

I. I understand that chronic opioid therapy has been associated with not only addiction and abuse, but also multiple medical problems including the suppression of endocrine function resulting in low hormonal levels in men and women, which may affect mood, stamina, sexual desire, and physical and sexual performance.

II. For female patients, if I plan to become pregnant or believe that I have become pregnant while taking this medication, I am aware that, should I carry the baby to delivery while taking these medications; the baby will be physically dependent upon opioids. I will immediately call my obstetrician and this office to inform them of my pregnancy. I am also aware that opioids may cause a birth defect, even though it is extremely rare.

I. I have been informed that long-term and/or high doses of pain medications may also cause increased levels of pain known as opioid induced hyperalgesia (pain medicine causing more pain) where simple touch will be predicted as pain and pain gradually increases in intensity and also the location with hurting all over the body. I understand that opioid-induced hyperalgesia is normal, expected result of using these medicines for a long period of time. This is only treated with addition of non-steroidal anti-inflammatory drugs such as Advil, Ibuprofen, etc., or by reducing or stopping opioids.

II. 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.

III. 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 be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. It occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or

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failure to respond well to opioids may cause my doctor to choose another form of treatment, reduce the dose, or stop it.

2.

I. All controlled substances must come from the physician whose signature appears below or during his/her absence by the covering physician, unless specific authorization is obtained for an exception.

II. I understand that I must tell the physician whose signature appears below or during his/her absence, the covering physician, all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death.

III. I will not seek prescriptions for controlled substances from any other physician, health care provider, or dentist. I understand it is unlawful to be prescribed the same controlled medication by more than one physician at a time without each physician's knowledge.

IV. I also understand that it is unlawful to obtain or attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician or his/her staff or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed).

3. All controlled substances must be obtained at the same pharmacy where possible. Should the need arise to change pharmacies; our office must be informed. The pharmacy that you have selected is:

_____Phone:_____

4.

I. You may not share, sell, or otherwise permit others, including your spouse or family members, to have access to any controlled substances that you have been prescribed.

II. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not make excessive phone calls for prescriptions or early refills and do not phone for refills after hours or on weekends.

5. Unannounced pill counts, random urine or serum, or planned drug screening may be requested from you and your cooperation is required. Presence or unauthorized substances in urine or serum toxicology screens may result in your discharge from the facility and its physicians and staff.

6. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the physician whose signature appears below or during his/her absence, by the covering

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physician, as set forth in section 2 above. I will not use, purchase, or otherwise obtain any illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance or any combination of substances (e.g., alcohol and prescription drugs), which impairs my driving ability, may result in DUI charges.

7. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on airplane, etc. If your medication has been stolen, it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told the authorities will not be enough.

8. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given.

9. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and other physicians at the facility and that law enforcement officials may be contacted.

10. I also understand that the prescribing physician has permission to discuss all diagnostic and treatment details, including medication, with dispensing pharmacists, other professionals who provide your health care, or appropriate drug and law enforcement agencies for the purpose of maintaining accountability.

11. I affirm that I have full right and power to sign and to be bound by this agreement, that I have read it, and understand and accept all of its terms. A copy of this document has been given to me.

_____

Patient's full name

_____ _____

Patient's signature **Date**

_____ _____

Physician's signature **Date**

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URINE TOXICOLOGY SCREENING/DISCHARGE PATIENT AGREEMENT

ALL Patients' WILL be subjected to random Urine Toxicology Screening

- If the urine toxicology screening comes back from the lab stating that a medication that was prescribed to you by Dr. Zhan was not traced in your system, YOU WILL BE AUTOMATICALLY DISCHARGED from our clinic with no exceptions.

- In the case that there is a trace of a "street drug" for example, cocaine, found in your system, as stated in our Pain Management Contract, YOU WILL BE AUTOMATICALLY DISCHARGED from our clinic with no exceptions.

NB: If for some reason you arrive to your appointment and cannot give a urine sample, we will not be able to give you your scripts until a urine sample is given.

OTHER VERY IMPORTANT PATIENT INFORMATION:

As also mentioned under our "Pain Management Contract", we are not obligated to write "Emergency Supply Scripts" and/or in any case continually write "Emergency Supply Scripts" for any of our patients. You are to follow the directions and quantity prescribed to you by Dr. Zhan. If you take more of a particular medication and run our early; we CANNOT renew your prescription early. Once the scripts are written and given to you and you walk out of our clinic it is your responsibility until your next 30 day follow-up with Dr. Zhan for your medications/scripts...we CANNOT refill and/or re-write any medications from that point forward. That also applies to LOST and/or STOLEN medications.

THANK YOU FOR YOUR UNDERSTANDING AND COOPERATION IN THIS MATTER!

I have read the above and clearly understand all responsibilities of Urine Toxicology testing as a patient of Dr. Zhan's and the possibility of being discharged.

Patient Agreement and Signature:_____ **Date:**___/___/_____

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PATIENT AGREEMENT:

If you are **unable** to keep your appointment, please contact us at least **24 – hours** before your scheduled time. Otherwise, a **$50.00 fee** will be charged for either a **late notice or no-show**.

Patient signature:_____ **Date:**_____

550 Orchard Park Rd, Bldg C, 2nd Fl, West Seneca, NY, 14224; Office: 716-677-2700; Fax: 716-677-2733

DR. SU ZHAN

WNY Rehab Medicine & Pain Mgmt
Su Zhan, MD, PhD
100 Union Rd
West Seneca, NY 14224

I GIVE MY PERMISSION TO RELEASE INFORMATION REGARDING MY MEDICAL CONDITION (HIPPA)

NAME _____

RELATIONSHIP _____

PHONE _____

NAME _____

RELATIONSHIP _____

PHONE _____

SIGNATURE OF PATIENT _____

DATE _____

DR. SU ZHAN

WNY Rehab Medicine & Pain Mgmt
Su Zhan, MD, PhD
100 Union Rd
West Seneca, NY 14224

PHONE 716-677-2700 FAX 716-677-2733

LAST NAME _____

FIRST NAME _____

DOB _____ E-MAIL _____

PHARMACY _____

PHARMACY
ADDRESS _____

CITY _____ STATE _____

ZIP _____ PHONE _____

EMERGENCY CONTACT

NAME _____

ADDRESS _____

CITY _____ STATE _____

PHONE _____

WNY REHABILITATION MEDICINE AND PAIN MANAGEMENT

DR SU ZHAN

100 UNION RD.

WEST SENECA, N.Y. 14224

PHONE: 716-677-2700

FAX: 716-677-2733

RELEASE OF MEDICAL INFORMATION

PATIENTS NAME: _____

DR. _____

PHONE: _____

FAX: _____

I, _____ AM AUTHORIZING MY MEDICAL RECORDS BE RELEASED TO DR. SU ZHAN.

SIGN: _____

DATE: _____