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

Relevant physical findings: _____

Location 1 (check all that apply)

Description of Pain		Effect on Resident
☐ Dull ache	☐ Comes and goes	☐ Appetite
☐ Throbbing	☐ Always present	☐ Mood
☐ Pressure/heaviness	☐ Localized	☐ Activity
☐ Burning	☐ Radiates	☐ Sleep
☐ Shooting	☐ Other	
☐ Sharp		

Score on pain scale*: _____

Pain medication last given: _____

Pain relieved according to resident goal: ☐ Yes ☐ No

Duration of relief: _____

Non-pharmacological interventions and effectiveness:

_____

Aggravating factors: _____

_____

Alleviating factors: _____

_____

Location 2 (check all that apply)

Description of Pain		Effect on Resident
☐ Dull ache	☐ Comes and goes	☐ Appetite
☐ Throbbing	☐ Always present	☐ Mood
☐ Pressure/heaviness	☐ Localized	☐ Activity
☐ Burning	☐ Radiates	☐ Sleep
☐ Shooting	☐ Other	
☐ Sharp		

Score on pain scale*: _____

Pain medication last given: _____

Pain relieved according to resident goal: ☐ Yes ☐ No

Duration of relief: _____

Non-pharmacological interventions and effectiveness:

_____

Aggravating factors: _____

_____

Alleviating factors: _____

_____

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Adverse reactions to medication/treatment

☐ Nausea	☐ Constipation	☐ Lethargy	☐ Rash	☐ None
☐ Vomiting	☐ Confusion	☐ Falls	☐ Urinary retention	☐ Other: _____
☐ Diarrhea	☐ Agitation	☐ Pruritis	☐ Headache	_____

Comments: _____

_____

_____

Pain Medication/Treatment Orders

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

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: _____

_____

Nurse Signature: _____ Floor/Unit: _____

Physician Signature: _____ Date: _____

Physician print name: _____

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