AMERICAN SOCIETY OF INTERVENTIONAL PAIN PHYSICIANS
THE VOICE OF INTERVENTIONAL PAIN MANAGEMENT

Risk Disclosure for the Pain Management Procedures During the COVID-19 Pandemic

Valley Of The Sun Institute For Pain Management, PLLC

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Facility OBS/ASC/Hospital: Phoenix Spine and Joint

Patient's name: ______________________________ **Date** ____________________

The novel corona virus COVID-19 has caused a global pandemic. Its clinical presentation varies from asymptomatic or mildly symptomatic, to life-threatening cardiopulmonary complications and death. Unfortunately, there is no effective treatment and a vaccine has not been developed yet. At this time, there is not enough evidence to conclusively determine whether pain management procedures have any positive or negative impact on the possibility of contracting the virus and/or development of any sequelae. Steroids are frequently used for pain injections. In high doses, steroids may have a negative effect on immunity, however, the therapeutic dose used for injections is generally low. Since COVID-19 is a new disease, and there is no conclusive evidence to suggest that injected steroids have any positive or negative effect on the COVID-19 disease. We will limit our steroid dose to the lowest effective therapeutic dose or in some cases steroids will not be injected at all. If your COVID-19 status is unknown, we cannot specifically comment on potential complications that may occur.

To reduce the risks associated with the COVID-19 infection, we are implementing safety precautions and following protocols consistent with the CDC and state recommendations. All patients and staff will be checked for fever or signs of illness upon entry to the facility. The risks, benefits, alternatives and decision to proceed with the procedure will be made in conjunction with you, the patient. However, we cannot guarantee that you will not become infected during your treatment at our practice.

By signing this written consent, you acknowledge that you have been informed about the potential risks to your health related to COVID-19 while undergoing treatments for your pain during this pandemic.

Patient's signature: ____________________ **Witness name:** ____________________

Physician Signature: ______________________________

CORONAVIRUS PATIENT CONSENT FORM

Our Governor allowed dental offices to re-open for elective treatment with certain safeguards. All patients, dentists and staff (both front and back) will be screened for COVID-19 daily.

The Center of Disease Control identified nine symptoms associated with Coronavirus.

1) **My Temperature** at ___ : ___ am/pm is ____°F. [The [illegible] office will fill in this line.] You will be asked to leave if your temperature meets or exceeds 100.4 °F. The CDC considers such a reading to indicate a fever.

Please complete all questions below. **In the past 24 hours:**

2) **Cough** Yes: ___ No: ___

3) **Muscle pain** Yes: ___ No: ___

4) **Headache** Yes: ___ No: ___

5) **Sore throat** Yes: ___ No: ___

6) **Shortness of breath or difficulty breathing** Yes: ___ No: ___

7) **Chills** Yes: ___ No: ___

8) **Repeated shaking with chills** Yes: ___ No: ___

9) **New loss of taste or smell** Yes: ___ No: ___

As of this morning, none of our doctors or staff exhibit any Coronavirus symptoms (using the same screening as above); however, we have NOT BEEN MEDICALLY TESTED for COVID-19 and cannot guarantee that either we or our other patients are Coronavirus-free.

For your safety, our office has increased hygiene measures since the outbreak.

Given this knowledge, and knowing that I possibly could contract COVID-19 at this office (through the doctors, staff, or from other patients, and despite the office's best intentions), I nevertheless voluntarily wish to continue with my elective [illegible] treatment and hold the doctor and staff harmless should I come down with Coronavirus.

I have read this page and the content in full and have **no questions.**

Dated this __ day of _________, 2020.

____
Patient/Guardian Signature

____
Temperature taken by (signature)

DALLAS PAIN QUESTIONNAIRE

Today's Date: ______________________

Patient's Name: ______________________ **DOB:** ______________________

Examiner: Estelle Farrell, D.O.

Please read carefully:

This questionnaire has been designed to give your doctor information as to how you pain has affected your life. Be sure that these are your answers. Do not ask someone else to fill out the questionnaire for you. Please mark an "X" in the appropriate box that expresses your thoughts from 1 to 100 in each section.

Section I: Pain and Intensity

To what degree do you rely on pain relieving substances for you to be comfortable?

None 0% | Some | All the time 100%

Section II: Personal Care

How much does pain interfere with your personal care (getting out of bed, teeth brushing, dressing, etc.)?

None (No Pain) 0% | *Some* | *I cannot get out of bed 100%*

Section III: Lifting

How much limitation do you notice in lifting?

None (I can lift as I did) 0 % | *Some* | *I cannot lift anything 100%*

Section IV: Walking

Compared to how far you walk before your injury or back trouble, how much does pain restrict your walking now?

I can walk the same 0% | *Almost the same* | *Very little* | *I cannot walk 100 %*

Section V: Sitting

Back pain limits my sitting in a chair to?

None, pain same as before 0 % | *Some* | *I cannot sit at all 100%*

Section VI: Standing

How much does your pain interfere with your tolerance to stand for long periods?

None, same as before 0 % | *Some* | *I cannot stand 100%*

Section VII: Sleeping

How much does pain interfere with your sleeping?

None same as before 0 % | *Some* | *I cannot sleep at all 100%*

Section VIII: Social Life:

How much does pain interfere with your social life (Dancing, games, going out eating with friends, etc.)?

None same as before 0% | *Some* | *No activities Total loss 100%*

Section IX: Traveling
How much does pain interfere you with traveling in a car?

None same as before 0 %		Some			I cannot travel 100%

Section X: Vocational
How much does pain interfere with your job?

None No Interference 0 %		Some			I cannot work 100%

Section XI: Anxiety/Mood
How much control do you feel that you have over demands made on you?

No change Total 0%		Some			None 100%

Section XII: Emotional Control
How much control do you feel that you have over your emotions?

No change Total 0%		Some			None 100%

Please Mark your Pain Level Below:

0	1	2	3	4	5	6	7	8	9	10

Section XIII: Depression
How depressed have you been since the onset of pain?

Not depressed Significantly 0%					Overwhelmed by depression 100%

Section XIV: Interpersonal Relationships
How much do you think your pain has changed your relationships with others?

Not changed 0%					Drastically changed 100%

Section XV: Social Support
How much support do you need from others to help you during this onset of pain (taking over chores, fixing meals, etc.)?

Not needed 0%					All the time 100%

Section XVI: Punishing Responses
How much do you think others express irritation, frustration, or anger toward you because of your pain?

None 0%		Some			All the time 100%