UPMC
LIFE CHANGING MEDICINE

☐ WHEELER FAMILY MEDICAL CENTER
126 E Church St., Suite 2400
(2nd floor)
Somerset, PA 15501
Phone: 814-443-5800
Fax: 814-443-5499

☐ JACOB W. SHIPLEY, MD
PAIN MANAGEMENT
410 Pellis Rd., Suite 1B
Greensburg, PA 15601
Phone: 814-443-5800
Fax: 814-443-5499

Welcome to Somerset Pain Management

Your healthcare provider has requested a consultation with our office to discuss comprehensive pain management. Please review and complete all paperwork PRIOR to your scheduled appointment time. Allow for approximately 45 minutes to complete the paperwork as accurately as possible. **Remember to bring the completed forms to your visit. (Failure to complete your paperwork may result in a rescheduling of your appointment.)**

PLEASE ARRIVE 20 MINUTES PRIOR TO YOUR FIRST SCHEDULED APPOINTMENT TIME.

Please bring the following:

- **Completed paperwork**
- **Current Driver's license**
- **Current Insurance Card**
- **Current Medication list with dosage and frequency**
- **Additional X-ray, CT or MRI reports (ONLY if performed outside of Somerset Hospital)**

The initial patient consultation will include a detailed pain history, physical exam, review of available diagnostic material, and a discussion of possible treatment modalities.

Several treatment modalities will require specific diagnostic testing as well as a detailed discussion regarding possible risks, benefits, and reasonable alternatives. Furthermore, your insurance will require office visit documentation before most treatment plans can be approved. **As such, your initial visit will not include prescribing controlled medications or performing injections.**

Should you need to cancel or change your initial appointment please notify our office **at least 24 hours in advance**, otherwise your rescheduling status will be placed in review.

Should you have any questions, please contact the office.

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Somerset Pain Management

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TREATMENT DISCLAIMER

UPMC Pain Management does not routinely prescribe narcotics as part of an integrative pain management approach at our Outpatient Center in Greensburg or UPMC Somerset locations. We request you discuss any opiate-based treatments with your primary caregiver. An opiate consultation can be made at the request of your PCP through our provider referral form.

Somerset Health Services
Patient Demographic Collection Sheet

Patient Name: _____ **Patient Social Security #:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cellphone:** _____

Sex (*circle one*): Male Female **Date of Birth:** _____

Marital Status (*circle one*): Single Married Widowed Separated Divorced

Email Address (if over the age of 18): _____

Primary Care Physician/Referring Physician: _____

Employment Status (*circle one*): Disabled Not Employed Retired Full Time Part Time Student

Race (*circle one*): White Asian American Indian/Alaskan Native Black/African American
Native Hawaiian More than One Race Other Pacific Islander Prefer not to Report

Ethnicity (*circle one*): Not Hispanic or Latino Hispanic or Latino Prefer not to Report

Primary Language (*circle one*): English Spanish Other: _____

If patient is under the age of 18, complete this section.

Legal Mother's Name: _____ **Legal Mother's Phone:** _____

Legal Father's Name: _____ **Legal Father's Phone:** _____

Guarantor Information (the guarantor is the person responsible for paying the bill)

Guarantor Name (must be a parent or guardian if under age 18): _____

Guarantor Social Security #: _____ **Guarantor Date of Birth:** _____

Subscriber Information (the subscriber if the person who is the policy holder)

Is the patient the policy holder for the health insurance coverage? Yes / No **If yes, skip this section.**

Policy Holder Name: _____ **Relationship to Patient:** _____

Policy Holder Date of Birth: _____ **Policy Holder Social Security #:** _____

Emergency Contact Information

Name of Emergency Contact: _____ **Relationship to Patient:** _____

Home Phone: _____ **Cell Phone:** _____

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Personal Representative Designation Form

Dear Patient:

We understand that you wish to appoint a personal representative to act on your behalf as described below. In regard to this matter, the privacy of your health care information is important to us. In the spaces below, provide the requested information about yourself (the patient) and the person you are designating to act as a personal representative concerning your health care information. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records accordingly, and speak to your personal representative.

Read this form carefully and then fill it out completely by printing or typing. If printing, use a pen.

Note that, subject to the disclaimers in the following paragraph, this form can be used to document the following types of personal representative activities on behalf of the patient:

- Make appointments for health care services;
- Have discussions with health care providers about routine tests and treatments (that do not require informed consent);
- Access to medical information, as necessary, to have discussions with health care providers about routine tests and treatments. However, unless the personal representative is a licensed physician who is credentialed to provide healthcare services at UPMC, use of UPMC's internal electronic medical record systems to access such medical information is not permitted.

Note that this form is <u>not applicable and cannot be used</u> for UPMC behavioral health patients or for any patient when major health care decisions are involved, including, but not be limited to:

- Procedures/services that require informed consent (and withdrawal of consent if applicable);
- Admissions to and discharges from nursing homes or other long-term care facilities;
- Donation of organs, body parts, or body for medical purposes, including the authorization of an autopsy;
- Continuation or withdrawal of life support; and
- For major health care decisions, a formal power of attorney or living will is required.

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Personal Representative Designation Form

This personal representative designation applies to the following UPMC entity/locations:

List all applicable entities: Somerset Health Services - UPMC Somerset Pain Management

REQUIRED INFORMATION:

Patient's Name:	Patient's Date of Birth:	Patient's Phone:
Patient's Address:		
Name of Patient's Personal Representative:		Personal Representative Phone:
Personal Representative Address:		Personal Representative Fax:
Any limitations on issues your personal representative may discuss? Yes _____ No _____ If yes, please specify:		
Expiration date for this designation (unless/until you specify in writing the expiration, this form will remain in effect until the patient no longer receives services at UPMC).		

REQUIRED SIGNATURES:

Personal Representative Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Please return this completed form by mail to: 126 East Church Street
Suite 2400
Somerset, PA 15501

or by fax to: 814-443-5499

Name_____ DOB:_____ Today's Date:_____

NEW PATIENT QUESTIONNAIRE

PRIMARY PAIN: **REFERRAL:**

Patient to fill out

Does your pain radiate? __No __Yes, it radiates to _____

How long ago did the pain start? __More than 3 months ago __ Less than 3 months ago

How did your pain develop? __ Gradually __ Suddenly

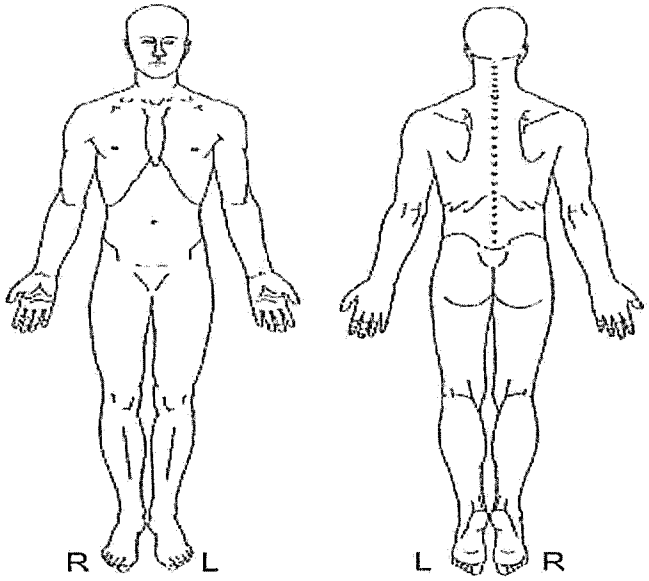
Since the pain started, how has it progressed? __Improved __ Worsened __Stayed the same

What do your symptoms feel like? __ Burning __ Stabbing __ Stinging __ Aching __Shooting

What is your **CURRENT** pain level? (0—1—2—3—4—5—6—7—8—9—10)

(0= no pain, 10=pain so severe you can't even speak)

Where is your pain? (Please shade **PRIMARY** area with arrows for **RADIATION**)



PAST MEDICAL HISTORY (*Select all that apply*)

__ Coronary Artery Disease
__ Stroke
__ Atrial Fibrillation
__ Myocardial Infarction (Heart Attack)
__ Congestive Heart Failure
__ Diabetes
__ Von Willebrands's Disease
__ Factor V Lieden
__ Pulmonary Embolism
__ Spinabifida
__ DVT
__ Thrombocytopenia (Low Platelets)
__ Cancer
__ Alcoholism
__ Opiate Dependency
__ Other: _____

Name_____ DOB:_____ Today's Date:_____

MEDICATIONS *(Please list dosage and frequency OR provide complete list)*

_____

_____

_____

DRUG ALLERGIES

_____

_____

SURGICAL HISTORY

_____

_____

_____

FAMILY HISTORY (Select all that apply)

__ Cancer ___ Bleeding Disorder __Rheumatological Disease __ Other:_____

SOCIAL HISTORY

Are you a smoker? __NO __YES

REVIEW OF SYSTEMS (*Please select all that apply)*

Constitutional:
__ chills __fever __weight loss

Skin: __rash __ulcers

HEENT: __blurred vision __ringing in ears __vertigo

Resp: __cough __wheezing __shortness of breath

CV: __chest pain __palpitations __edema

GI: __constipation __diarrhea __heartburn

Neuro:
__fainting __seizures

Psychiatric:
__tired __ fogginess __personality changes

Endocrine:
__ sweating __hot flash __sexual dysfunction

Hematology:

__easy bruising __easy bleeding __ nose bleeds