

Opioid Progress Report

Chronic, Non-Cancer Pain

WORKER	Worker's Name	Worker's Signature	Today's Date	Claim Number
	<p>1. On average, how bad was your pain last week? (circle number) 0= no pain 10= worst possible pain 0 1 2 3 4 5 6 7 8 9 10</p> <p>2. What activities are most difficult because of pain? Activities may include sitting, standing, walking, reaching overhead, climbing stairs, etc.</p> <p>Pick 2 activities and mark the changes from your last doctor visit. Please use the same activities each time you complete this form.</p> <p>Activity 1: _____ I can do: <input type="checkbox"/> more <input type="checkbox"/> less <input type="checkbox"/> no change</p> <p>Activity 2: _____ I can do: <input type="checkbox"/> more <input type="checkbox"/> less <input type="checkbox"/> no change</p>			

PROVIDER	<p>PROGRESS REPORT (check all that apply)</p> <p>(circle number)</p> <p><input type="checkbox"/> Estimate worker's function on opioids 0 1 2 3 4 5 6 7 8 9 10 0= severe impact on function 10= returned to level of function prior to injury</p> <p><input type="checkbox"/> Worker has a signed opioid agreement within past 6 months Last date of agreement: _____ (If new agreement, please submit copy)</p> <p><input type="checkbox"/> Is there concern about opioid use? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check all that apply <input type="checkbox"/> Misuse <input type="checkbox"/> Tolerance <input type="checkbox"/> Dependence <input type="checkbox"/> Toxicity/side effects</p> <p>Have you requested a random drug test? If so, please submit a copy Random drug screening is recommended and does not require pre-authorization</p> <p>RECOMMENDATION/TREATMENT PLAN (check all that apply)</p> <p><input type="checkbox"/> Worker has reached maximum medical improvement (MMI)</p> <p><input type="checkbox"/> I will continue to prescribe opioids and monitor</p> <p><input type="checkbox"/> I have started to wean worker from opioids and will finish by _____</p> <p><input type="checkbox"/> I referred for pain management consultation to Dr. _____ Date: _____</p> <p><input type="checkbox"/> I need additional resources to assist me in managing this worker's pain. Please specify:</p> <p><input type="checkbox"/> Other (please explain)</p>				
-----------------	---	--	--	--	--

SIGN	Signature: <input type="checkbox"/> Doctor <input type="checkbox"/> ARNP <input type="checkbox"/> PA-C	Phone Number:	Date:
	Print Name:	Provider or NPI Number :	