Follow-Up Acknowledgements
Life Extension Wellness Center Inc.
1418 S. Federal Hwy, Dania Beach, FL 33004
Telephone:(954) 921-9555 Fax: (954) 921-9556
Dr.______________________________

Medications Must Be Taken As Prescribed

- Snorting, crushing, injecting, or any other use **other than directed as prescribed** can result **in serious medical problems including death** and will result in you being discharged.
- If you were **arrested for a drug related crime**, you will be discharged.
- **Doubling up** or taking medications more **frequently than prescribed can result in serious medical problems including death** and may result in your discharge from this clinic.
- **Combining** other sedating medications, such as alcohol, benzodiazepines, barbiturates, other opioids, street drugs, or over the counter sedating medications, without prior approval of the prescribing physicians will result in your discharge from this clinic.
- If you are pregnant you **must alert** the doctor or staff.
- Lost, stolen, or misplaced narcotics **will not be replaced under any circumstances**. It is your responsibility to report any incident involving your medications to the police as soon as possible.

Patient Portion

Other than medications you are being prescribed by **Dr.**______________________________what else have you done to alleviate **(lessen)** your pain?
PLEASE EXPLAIN:

Were there any changes in activities that exacerbated (Make worse) your pain during the past month?

YES________ NO________

IF YES PLEASE DESCRIBE:

- By Florida statute 893.13, it is a **Third Degree Felony**, punishable by up to five years in prison and a 5,000 fine if:
  1. You do not tell **Dr.**______________________________who prescribes your narcotic pain medication that you have received narcotic pain medication from another physician which time frame overlaps with your visit to this, or any other, facility.
  2. You posses or attempt to possess narcotic pain medication by misrepresentation, fraud, forgery, deception, or subterfuge.

By signing this document, I hereby swear under penalty or perjury that I have not been prescribed narcotic pain medication from another physician for any time that would overlap for my visit to **Life Extension Wellness Center, Inc**. and that I am in full compliance with Florida Statute 893.13 as outlined in the above paragraphs.

Printed Name: ________________________ Signature: X______________________

Contact Info: __________________________ Date: ______/______/______

Email Address: ________________________

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Please answer each question as honest as possible. Keep in mind that we are only asking about the past 30 days. There is no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

CHECK APPROPRIATE BOX

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?					
In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief for medications? (For example, another doctor, the emergency room, friends, street sources)					
In the past 30 days, how often have you taken your medications differently from how they are prescribed?					
In the past 30 days, how often have you seriously thought about hurting yourself?					
In the past 30 days, how often have you had trouble controlling your anger? (For example, road rage, screaming, arguments, etc.)					
In the past 30 days, how often have others been worried about how you're handling your medications?					
In the past 30 days, how often have you used your pain medicine for symptoms other than pain? (For example, to help you to sleep, improve your mood or relieve sleep)					
In the past 30 days, how many times have you use any form of cocaine or illegal drugs?					

Patient's Print Name:____________________________ Signature:____________________________ Date: ____________

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Dr. ______________________________

Name: ___________________________ Date: _________________

Occupation: _______________________ D.O.B._________________

Please check all areas you are having pain right now ____Neck ____ Upper Back/Shoulders ____Headache

_____ Mid Back _____ Low Back _____ Buttocks/Hip _____ Leg/Foot Other __________

Reason for needing more than 72 hours of pain medication:

____ Long term chronic pain ____ Long term medication history ____ Chronic illness

What is your goal of treatment ______To be pain free _______ Improve activities of daily life
______ Improve quality of life

Please rate on the scale below your pain when **NOT ON PAIN MEDICATION:**
0___ 1___ 2___ 3___ 4___ 5___ 6___ 7___ 8___ 9___ 10___
Please rate on the scale below when **ON PAIN MEDICATION**:
0___ 1___ 2___ 3___ 4___ 5___ 6___ 7___ 8___ 9___ 10___
Please rate on the scale below when ON PAIN MEDICATION:______________________ ***When was the last time you took the pain medication?***

Do you currently have a Primary Care Physician? ______________________________
Are you pregnant? ___ Yes ____ No ___N/A

Side effects from medications: ___ NO ___ Yes___ If Yes, Describe: _________________

Sleep: No problems _____ Insomnia _____ awakening due to pain: ___

Sleep improved with medication? _____ No _____ Yes

Anxiety: No problems ____ Severity: Mild ____ Moderate ____ Severe ____ Generalized ____ Pain attack _____

Improve with medication? No _____ Yes _____

Mood: No problems _____ Depression: Mild _____ Moderate _____ Severe _____

Aggravating Factors (if any): Work _____ Weather _____ Prolonged Sitting/Standing _____ Driving _____

Bending/Lifting _____ Head movement _____

List medication(s) you are currently prescribed:

_____________________ ____ mg ____ x's a day _____________________ ____ mg ____ x's a day
_____________________ ____ mg ____ x's a day _____________________ ____ mg ____ x's a day
_____________________ ____ mg ____ x's a day _____________________ ____ mg ____ x's a day
_____________________ ____ mg ____ x's a day _____________________ ____ mg ____ x's a day

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Patient's Print Name:__________________________ Signature:__________________________ Date: ____________

(PLEASE INITIAL EACH LINE)

PAIN MANAGEMENT PATIENT INFORMED CONSENT/TREATMENT AGREEMENT

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This Agreement is to help you and your provider to comply with the law regarding controlled pharmaceuticals.

_____ I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

_____ I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this 1`Agreement.

_____ I understand that if I break this Agreement, my provider will stop prescribing these pain control medicines.

_____ In this case, my provider will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

_____ I would also be amenable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems necessary.

_____ I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

_____ I will notify my provider if I begin taking Medical Marijuana.

_____ I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to times when I am not driving or operating machinery and will be infrequent.

_____ I will not share my medication with anyone.

_____ I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider, unless your Pain Management Physician at Extended Life Wellness, Inc., and the other prescribing physician has been previously notified and both have agreed to the therapeutic regimen.

_____ I will safeguard my pain medication from loss, theft, or unintentional use by others, including youth. Lost or stolen medications will not be replaced.

_____ I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

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(PLEASE INITIAL EACH LINE)

_____ I agree to use this pharmacy ________________________________ located at this address _________________________________ with the telephone number of _____________ for filling my prescriptions for all of my pain medicine.

_____ I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my provider to provide a copy of this Agreement to my pharmacy, primary care provider and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ I agree that I will be prepared each month to submit to a blood or urine test if requested by my provider to determine my compliance with my program of pain control medications.

_____ I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program web site periodically throughout my treatment period.

_____ I agree that I will use my medicine at a rate no greater that the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

_____ I will bring unused pain medicine to every office visit.

_____ I agree to follow these guidelines that have been fully explained to me.

_____ I acknowledge that if I do not comply with these guidelines, I will be discharged from Life Extension Wellness Center and/or referred to an addiction specialist.

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this _____ day of ________________________, 201___.

Patient Signature: ____
Patient Name (printed):____

Provider signature: ____
Provider Name (printed):____

Witnessed by:
Signature: ____
Name (printed):____