

CHRONIC PAIN MANAGEMENT
(Addendum To Application for Physicians and Surgeons)

DO YOU PERFORM ANY OF THE FOLLOWING PROCEDURES?	# of Procedures Done Annually		
1. Epidural Injections			
a. Cervical	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
b. Thoracic	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
c. Lumbar	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
d. Caudal	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
e. Selective nerve root block (transforaminal)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
2. Facet Injections			
a. Cervical	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
b. Lumbar	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
3. Joint Injections			
a. Sacroiliac	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
b. Gleno-humeral	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
c. Knee	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
d. Hip	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
If yes, explain _____			_____
_____			_____
4. Celiac Plexus Blocks	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
5. Spinal Endoscopy			
a. Percutaneous laser discectomy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
b. Epiduroscopy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
c. Intradiscal electrothermal treatment (IDET)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
d. Racz catheter epidurolysis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
6. Neurolysis Procedures			
a. Radiofrequency	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
b. Cryoablation	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
c. Intrathecal neurolytic solutions	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
d. Other (Please specify below)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
_____			_____
_____			_____
7. Insertion of spinal cord stimulators	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
a. Do you go higher than vertebral level T4?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
b. Is placement verified with fluoroscopy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
c. Have you been trained through a program of study that incorporates hands-on experience?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
d. Have you been credentialed by a hospital to perform these procedures?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
If yes, please provide the name of the hospital(s).			_____
_____			_____
e. Do you have an established program for routine follow-up care and emergency contact procedures?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
If yes, explain _____			_____
_____			_____

8. **Insertion of epidural catheter for drug infusion** Yes No _____
 (Do not include post-op epidural for acute pain management.)
- a. Do you go higher than vertebral level T4? Yes No
- b. Is placement verified with fluoroscopy? Yes No
- c. Have you been trained through a program of study that incorporates hands-on experience? Yes No
- d. Have you been credentialed by a hospital to perform these procedures? Yes No
 If yes, please provide the name of the hospital(s). _____
- e. Do you have an established program for routine follow-up care and emergency contact procedures? Yes No
 If yes, explain _____
9. **Insertion of intrathecal catheter for drug infusion** Yes No _____
- a. Do you insert the catheter at a level higher than vertebral level L2? Yes No
- b. Is placement verified by fluoroscopy? Yes No
- c. Have you been trained through a program of study that incorporates hands-on experience? Yes No
- d. Have you been credentialed by a hospital to perform these procedures? Yes No
 If yes, please provide the name of the hospital(s). _____
- e. Do you have an established program for routine follow-up care and emergency contact procedures? Yes No
 If yes, explain _____
10. **Are you prescribing opiate analgesics?** Yes No
- a. If yes, are you contacting the primary physician to learn about drug habits? Yes No
- b. Do you discuss with the patient and document in the patient's chart, the conditions and limitations under which opiates will be prescribed? Yes No
- c. Do you require the patient to sign a document specifying the conditions and limitations under which opiates will be prescribed? Yes No
11. **What new techniques do you now use which you did not use 3 years ago?** _____
12. **Are you certified in Pain Medicine?** Yes No
- a. By the ABA? Yes No
- b. By the American Board of Pain Medicine? Yes No
- c. Other? (Please specify below) Yes No

13. **What percentage of your practice is devoted to chronic pain management?** _____

 Signature

 Date

 Please Print Name