

Pain Management Communication

Physician/ARNP Name: _____

Patient Name: _____ DOB: ____/____/____

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|--|--|
| <input type="checkbox"/> Cognitively Impaired? (check if yes) | Observed Behaviors: <input type="checkbox"/> Whining <input type="checkbox"/> "Ouch" <input type="checkbox"/> Winces <input type="checkbox"/> Bracing <input type="checkbox"/> Gasping <input type="checkbox"/> "That hurts" <input type="checkbox"/> Wrinkled forehead <input type="checkbox"/> Guarding <input type="checkbox"/> Furrowed brow <input type="checkbox"/> Rubbing body part/area <input type="checkbox"/> Clenched jaw <input type="checkbox"/> Clutching/holding body part/area during movement <input type="checkbox"/> Guarding <input type="checkbox"/> Other: _____ |
|--|--|

Pain Intensity: _____

(Before meds)

(After meds)

Standard pain scale used:

Numeric Rating Scale (0-10)

Verbal Descriptor Scale (no pain, mild pain, moderate pain, severe pain, extreme pain, pain as bad as could be)

Faces Pain Scale

PAINAD; score: _____

Other: _____

Pain Interferes with: Sleep Ambulation Appetite Activities Transfers

Types of Pain:

Neuropathic

Nociceptive (Joint/bone/soft tissue)

Other: _____

Location(s) of Pain: _____

Pain Pattern: Constant Intermittent

Constant with Breakthrough

Quality of pain (use descriptive adjectives of patient): Aching Burning Cramping

Crushing Dull Numbness Pins & Needles Sharp Stabbing Throbbing

Other: _____

Current analgesic regimen: _____

Analgesics tried in the past: _____

Relevant side effects: _____

Treatment Suggestions

Patient/Family requests

Nurse requests

Date: ____/____/____

RN Signature: _____

New Orders

Continue Same Orders

Change Orders as Follows:

Date: ____/____/____

Physician/ARNP Signature: _____