Pain Management Communication

Physician/ARNP Name: _____

Patient Name: _____ DOB: _____/_____/_____

☐ Cognitively Impaired? (check if yes)	Observed Behaviors: ☐Whining ☐"Ouch" ☐Winces ☐Bracing ☐Gasping ☐"That hurts" ☐Wrinkled forehead ☐Guarding ☐Furrowed brow ☐Rubbing body part/area ☐Clenched jaw ☐Clutching/holding body part/area during movement ☐ Guarding ☐ 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: _____

Cancer Pain in Elders: Promoting EBP's in Hospices
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