MEDICATION REFILL POLICY

NCH PHYSICIAN GROUP – NEUROSURGERY

To ensure the safety of all patients, NCH Neurosurgery has a comprehensive policy for medication refills. **It is very important to plan ahead.**

It takes 1-3 business days to refill your prescriptions. We must review your medical record, check for expiration dates, verify number of refills, and ensure refill eligibility. Please contact us at least 3 days before your medication is due to run out to request a refill. Please note that prescriptions are not refilled on weekends or after 4:30 pm on weekdays.

Refill requests can also be made through your pharmacy. The pharmacy will forward the information we need to our office and after confirmation, it is presented to the provider for final authorization. Certain medications require laboratory testing before they can be refilled.

- Strict controls are in place for medications containing opioids. Florida law prohibits opioids from being called into the pharmacy. Patients must be seen in the office for non-refillable pain medications to be refilled.
- The law requires a 3-day limit on opioid prescriptions for acute pain. It is very important for patients taking opioid medication to take them as prescribed by the provider.
- Refills on medications can only be authorized on medications that were prescribed by Dr. Edison Valle. Dr. Valle will not refill medications prescribed by any other providers.
- Prescriptions may not be mailed or shipped. Controlled substance prescriptions must be picked up in the office. All other medications may be sent in electronically to your pharmacy if they participate in electronic prescribing.
- Please understand that pain medications are prescribed for patients undergoing surgery or a procedure only. If you do not require either of these, you may be referred to pain management for pain control.
- If your pain persists for more than 2 months after your date of surgery, schedule an appointment with your provider to be evaluated for a possible referral to Pain Management.

Thank you for understanding and complying with the medication policies.

Patient Signature_____Date_____

BRAIN SERVICES PATIENT INTAKE FORM: PATIENT SECTION

□ CLINIC NEW PATIENT □ CLINIC CONSULT – REQUESTED BY: _____

HISTORY:

What is your chief complaint?

_____

_____

In your own words, explain WHEN and HOW your symptoms began. _____

_____

_____

_____

Who has referred you to us? Name: _____

Address & Phone #: _____

Is this your Primary Care Physician? □ Yes □ No? If not, who is your Primary Care Physician?

Name: _____

Address & Phone #: _____

What diagnosis has your physician given you? _____

Describe the symptoms for which you are being referred?

□ Headaches □ double vision □ balance abnormality □ weakness □ face pain □ facial drop

□ loss of hearing □ loss of vision □ ringing on the ears □ lack of smell or taste □ trouble swallowing

□ speech abnormality □ tremors □ neck stiffness □ intolerance to daylight □ Other:

_____

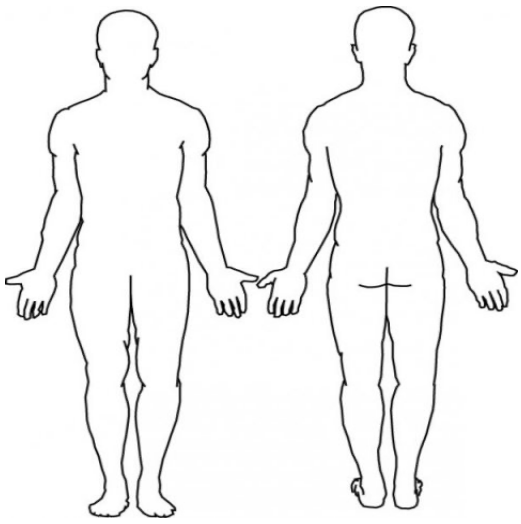
How did your current symptoms begin?

□ suddenly □ gradually □ trauma: _____

PAIN DRAWING – If you have pain, where is your pain now?

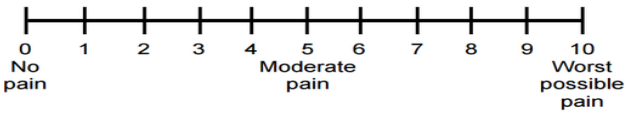
Mark the areas on your body where you feel the sensation described below using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face.

Aching	*Numbness*	*Pins & Needles*	*Burning*	*Stabbing*
^^^	===	ooo	XXX	///



BRAIN SERVICES PATIENT INTAKE FORM: PATIENT SECTION

On a scale of 0 – 10, mark the level of pain/discomfort,
with 0 being none and 10 being unbearable (mark only one)



If pain, how would you describe your pain?

☐ sharp ☐ dull ☐ deep ☐ superficial ☐ constant ☐ intermittent ☐ Other:_____

How long have you had your symptoms?
☐ 1-7 days ☐ 8-14 days ☐ 15-21 days ☐ 22-28 days ☐ 1 month ☐ 2 months ☐ 3 months
☐ 6 months ☐ 9 months ☐ more than 1 year - # years _____

What makes your symptoms worse?
☐ lying down ☐ sitting ☐ standing ☐ walking ☐ bending forward ☐ bending backward
☐ coughing ☐ neck flexion ☐ neck extension ☐ neck rotation ☐ never worsens
☐ Other: _____

What makes your symptoms better?
☐ lying down ☐ sitting ☐ standing ☐ walking ☐ leaning on shopping cart ☐ nothing
☐ manipulation (PT, chiropractic, massage) ☐ narcotics ☐ anti-inflammatory / aspirin
☐ neck flexion ☐ neck extension ☐ neck rotation ☐ Other:
_____

Has there been any change in your bowel and bladder habits (incontinence)?
☐ no ☐ yes – Describe: _____

What other treatments have you had for your current problem? Please explain any "yes" answers in the space below

Chiropractic treatment for this illness or injury? ☐ Yes ☐ No
Physical therapy? ☐ Yes ☐ No
Have you ever received steroid injection for this problem? ☐ Yes ☐ No
Have you ever had radiation? ☐ Yes ☐ No How long ago? _____ months / years
Have you ever received a Medrol (steroid) dose pack for this problem? ☐ Yes ☐ No
Have you taken prescription medication for this problem? ☐ Yes ☐ No
Have you ever had any surgery for your current problem? ☐ Yes ☐ No ☐ If yes, how many? _____
If you have a **VP- shunt,** do you know the Valve type and the Current settings? _____
Have you ever been hospitalized for this problem? ☐ Yes ☐ No
Have you ever had any endovascular / catheter base treatment for your current problem? ☐ Yes ☐ No
If yes, how many? _____
Ever been treated for depression, anxiety, or mental health issues? ☐ Yes ☐ No
Would you be willing to consider surgery for your symptoms? ☐ Yes ☐ No

BRAIN SERVICES PATIENT INTAKE FORM: PATIENT SECTION

Do you currently have any of these symptoms? Please check "Yes" or "No" for each symptom.

Yes	No	Constitutional Symptoms
		Fever
		Night Sweats
		Generalized Weakness or Fatigue
		Weight Gain
		Weight Loss

Yes	No	Cardiovascular
		Shortness of Breath
		Chest Pain
		Irregular Heartbeat
		Palpations

Yes	No	Respiratory
		Coughing up Blood
		Chronic Cough
		Wheezing

Yes	No	Gastrointestinal
		Blood in Stool
		Black or Discolored Stool
		Abdominal Pain
		Difficulty Swallowing
		Nausea or Vomiting
		Diarrhea
		Constipation
		Abdominal Distention
		Abdominal Mass or Lumps

Other: _____
_____
_____
_____
_____
_____

Yes	No	Genito-urinary
		Burning with Urination
		Dark or Discolored Urine
		Difficulty Starting or Ending Urine Stream
		Poor Bladder Control
		Loss of Genital Sensation
		Any Type Sexual Dysfunction

Yes	No	Skin/Breast
		Dry Skin
		Body Rash or Hives
		Nipples Discharge
		Breast Lump
		Problems with Wound Healing
		Change in a Mole
		Dimpling of Skin
		Change in Color or Temperature of Skin

Yes	No	Hematologic / Lymphatic
		Easily Bruises or Bleeds
		Nose Bleeds

Yes	No	Musculoskeletal
		Masses or Lumps
		Swelling
		Inability to Feel Hot or Cold
		Poor Coordination
		Loss of Control of Arms or Legs
		Loss of Muscle Mass
		Abnormal Arm or Leg Sensations
		Neck Pain
		Back Pain
		Numbness
		Tingling
		Muscle Spasms

Yes	No	Neurological
		Poor Vision
		Blurry Vision
		Double Vision
		Loss of Hearing
		Ringing in Ears
		Numbness in Face
		Loss of Sense of Smell
		Loss of Sense of Taste
		Droopy Face or Eye
		Hoarseness
		Difficulty Speaking
		Difficulty Swallowing
		Slurred Speech
		Headache
		Dizziness
		Seizures
		Unsteady Gait

Yes	No	Endocrine
		Poor Appetite
		Cold Intolerance
		Excessive Thirst
		Loss of Body Hair
		Psychosocial
		Depression
		Hallucinations
		Anxiety
		Mood Swings

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BRAIN SERVICES PATIENT INTAKE FORM: PATIENT SECTION

Have you ever had any of the following medical conditions? Please check yes or no to all the following.

MEDICAL HISTORY: **YES** **NO**

Hypertension (high blood pressure) _____ □ □
Dyslipidemia (high or low cholesterol) _____ □ □
Diabetes (too much sugar in bloodstream) ____ □ □
Diabetes type: controlled / uncontrolled
Peripheral Vascular Disease
(blocked blood vessel in legs) _____ □ □
TIA / Stroke _____ □ □
Heart Disease _____ □ □
Syncope (fainting) _____ □ □
Kidney Disease _____ □ □
BPH (enlarged prostate gland) _____ □ □
GI Ulcer _____ □ □
Asthma / Lung Disease _____ □ □
Anemia _____ □ □
Lupus/Rheumatoid Arthritis/ □ □
Ankylosing Spondylitis
Cancer _____ □ □
Date_____ Type_____
Other: _____
_____
_____

SURGICAL HISTORY – Please list any prior surgeries
_____
_____
_____
_____
_____
_____

FAMILY HISTORY

Relationship	Medical History	Cause of Death (if applicable)
Father		
Mother		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		

SOCIAL HISTORY

Tobacco **YES** **NO**
Currently Smoking _____ □ □
Quit Date: _____
Packs per day _____ Years _____
Illicit Drugs _____ □ □
Occasional _____ □ □
Drinks Per Week _____
Quit Date _____
Occupation _____
_____

MEDICATIONS

_____
_____
_____

ALLERGIES

_____
_____

WORK HISTORY

Are you able to perform your daily routine with these symptoms? □ Yes □ No

Are you able to work with your condition? □ Yes □ No

Have you ever filed a Worker's compensation claim related to a neck or brain injury? □ Yes □ No □ N/A

Have you been or will you be involved in a lawsuit because of your neck or back problem? □ Yes □ No

Is lawsuit settled? □ Yes □ No

BRAIN SERVICES PATIENT INTAKE FORM: PATIENT SECTION

Patient Signature **Date / Time**

_____

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