

Communication Worksheet for Pain Interventions

Person's Name _____

PPS: _____

Physician _____ Phone _____

Pharmacy _____ Phone _____

Diagnosis: _____

Allergies: _____

Location of Pain: _____

Quality of Pain: _____

Intensity of Pain: _____

Associated Symptoms: _____

Analgesic Medications received in the past 24 hours - drug, dose, route and #BTP doses given:

Analgesic Medications tried in the past: _____

Suggestions for changes in management: _____

New Orders: _____

Nurse Signature: _____

Date _____

Changes made: on Dr. Order Form Yes No

on Medication Form Yes No

Medications Ordered (if necessary) Yes No