

Pain Management Questionnaire

Name _____ Policy Number _____

Number of patients seen per week for pain management _____ Number of procedures done per week for pain management _____

BREAKDOWN OF WEEKLY PROCEDURES IN THE:

Office ASU* Hospital

Total number of procedures _____

Number of interventional procedures _____

Percent of practice _____

PROVIDE A BREAKDOWN OF YOUR PAIN PRACTICE:

None 0 to 10% 10% to 25% 25% to 50% >50%

Medication Management _____

Interventional Pain Management _____

DESCRIBE YOUR TRAINING IN PAIN MANAGEMENT:

Are you Board certified? Yes No Describe _____

Have you completed a pain fellowship? Yes No Describe _____

Other _____ Describe _____

DO YOU PERFORM ANY OF THE FOLLOWING PROCEDURES:

Nerve blocks Yes No Type _____

Sympathetic blocks Yes No Type _____

Peripheral nerve blocks Yes No Type _____

Epidurals Yes No Type _____

Facet injections Yes No Type _____

Injection anesthetic agent Yes No Type _____

Other _____ Type _____

Radiofrequency denervation Yes No Type _____

Trail and permanent spinal cord stimulator Yes No Type _____

Implantable pumps Yes No Type _____

Percutaneous nucleoplasty Yes No Type _____

IDET Yes No Type _____

Discography Yes No Type _____

Are procedures fluoroscopically guided? Yes No Type _____

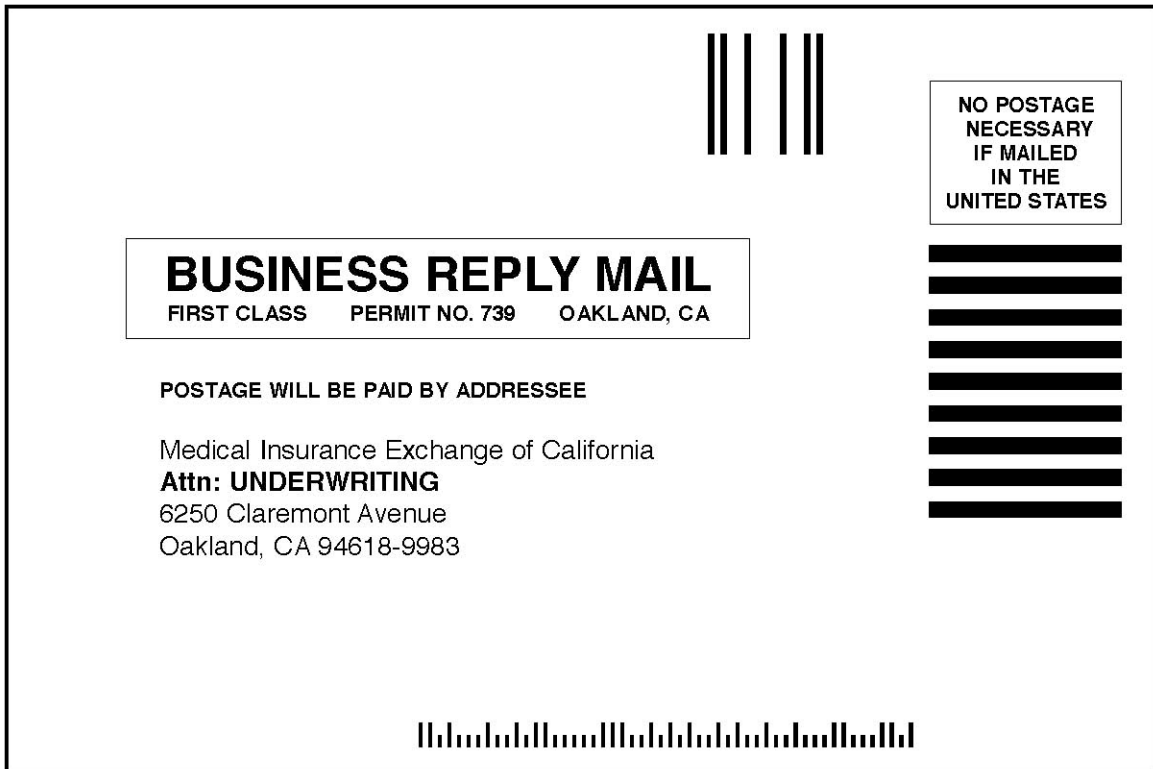
Are you a member of a pain organization? Yes No List _____

Attach a copy of the pain management agreement you ask patients to sign

*Ambulatory Surgical Unit

Remember to attach a copy of the pain management agreement you ask patients to sign. You can send it in by:

1. Mail – [Print PRE-PAID Mailing label]
2. Fax – (510) 654-4634
3. E-mail – Underwriting@MIEC.com



PRE PAID MAILING LABEL – PLEASE FIRMLY ATTACH TO YOUR ENVELOPE