PROGRESS NOTE Pain Assessment and Documentation Tool (PADT™)

			Г	F	Patient Stamp H	ere	
Pa	tient Name:	Record +	#:				
	ssessment Date:	Record #	<i></i> -				
Λ3	sessifient Date.						
			L	_		_	
		Current Analg	esic Regimen				
Dr	rug name	Strength (eg, mg)	Frequency	Maxi 	mum Total	Daily Dose	
Act Th	e PADT is a clinician-directed interview; th tivities of Daily Living, and Adverse Events e Potential Aberrant Drug-Related Behavions ns below, except as noted.	sections may be comple	ted by the physician, nurse pro	ctitioner, ‡	hysician assis	tant, or nurse	
	Analgesia		Activities of Daily Living				
ba lev	zero indicates "no pain" and ten ind d as it can be," on a scale of 0 to 10 rel of pain for the following question What was your pain level on avera past week? (Please circle the appro	0, what is your ns?	Please indicate whether the patient's functioning with the current pain reliever(s) is Better, the Same, or Worse since the patient's last assessment with the PADT.* (Please check the box for Better, Same, or Worse for each item below.)				
	past week! (Flease circle the appro			Better	Same	Worse	
No	Pain 0 1 2 3 4 5 6 7 8 9	Pain as bad as it can be	1. Physical functioning				
	What was your pain level at its wo past week?		2. Family relationships	; -		٥	
No	Pain 0 1 2 3 4 5 6 7 8 9	as it can be	3. Social relationships				
3.	What percentage of your pain has during the past week? (Write in a between 0% and 100%.)	percentage	4. Mood			۵	
4.	Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference in your life?		5. Sleep patterns				
	Yes No		6. Overall functioning				
5.	Query to clinician: Is the patient clinically significant? ☐ Yes ☐ No	t's pain relief ☐ Unsure	* If the patient is receiving the clinician should comp with other reports from	oare the pa	tient's function		

(Continued on reverse side)

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A	dverse	Event	ts		Potential Aberrant Drug-Related Behavior This section must be completed by the physician .		
Is patient exper current pain rel Ask patient about	liever(s)?	ĹYe	s 🗆 No	1	Please check any of the following items that you discovered during your interactions with the patient. Please note that some of these are directly observable (eg, appears intoxicated), while others may require more active listening and/or probing. Use the "Assessment" section		
Ask pacient abou	it potenti	ai side e	nects.		below to note additional details.		
	None	Mild	Moderate	Severe	☐ Purposeful over-sedation☐ Negative mood change		
a. Nausea					☐ Appears intoxicated		
					☐ Increasingly unkempt or impaired		
b. Vomiting					Involvement in car or other accident		
c. Constipation					Requests frequent early renewals		
d. Itching					☐ Increased dose without authorization☐ Reports lost or stolen prescriptions		
e. Mental cloudine					Attempts to obtain prescriptions from other doctors		
f. Sweating					☐ Changes route of administration		
g. Fatigue					☐ Uses pain medication in response to situational stressor		
h. Drowsiness					☐ Insists on certain medications by name		
i. Other					☐ Contact with street drug culture		
					☐ Abusing alcohol or illicit drugs		
j. Other			J	"	☐ Hoarding (ie, stockpiling) of medication☐ Arrested by police		
3 D.:			"		☐ Victim of abuse		
2. Patient's overall ☐ None ☐ Mile	•	of side Modera		evere	Other:		
	. .	i lodela		2,016			
opioid therapy?	ression tl Yes	hat this	patient is be	enefiting (e physician.) eg, benefits, such as pain relief, outweigh side effects) from I Unsure		
Specific Analge	esic Pla	n:					
☐ Continue present regimen Comments: _							
☐ Adjust dose of pr	resent and	algesic					
☐ Switch analgesics	;						
☐ Add/Adjust conce	omitant tl	herapy					
☐ Discontinue/tape	er off opio	oid thera	ру				
Date:			Physicia	n's signatu	ro·		

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