HOSPITAL OF

INITIAL ACUTE PAIN MANAGEMENT SERVICES

Date: ____________
To: Acute Pain Service
From: Dr. ___________________ (Attending)
on ___________________ (Service)
__________________________________________ Diagnosis or body site

Time: ____________ Date: ____________

EPIDURAL ANALGESIA:
☐ Epidural placement for post-op analgesia (62279)
   (epidural not used as primary anesthetic route)
☐ Epidural used intra-op as primary anesthetic route
   (not billable - included in other services)

REQUIRED:
Chief Complaint:
Hx. of Present Illness:

Physical Exam of affected area:
Lab / X-rays:
Allergies:
Meds:

IMPRESSION:

PLAN: ☐ IV PCA ____________ Drug ____________
   ☐ Basal Rate ____________ Bolus ____________ PCA Dose ____________ Delay ____________ HR Limit
   ☐ Epidural Analgesia ____________ Drug ____________ Hour Rate ____________
   ☐ Other: ____________
   ☐ Pt understands and agrees with the treatment plan

Name: ___________________ Signature: ___________________ ID: ____________

PHYSICIAN INSERTING OR SUPERVISING THE INSERTION OF EPIDURAL
SHOULD FILL OUT THIS FORM AND SIGN

White - CONSULT NOTE  Yellow - WORKBOOK  Pink - Billing