PROFESSIONAL LIABILITY ASSOCIATION, LLC

CARE RISK RETENTION GROUP, INC

PAIN MANAGEMENT SUPPLEMENT

1. Certification:

   Anesthesia ☐ Yes ☐ No

   Pain Management ☐ Yes ☐ No

   Other _____

2. Fellowship in pain management _____ Date _____

   If no formal fellowship, please list any other applicable training, including all CME credits in pain management in the past 3 years _____

   _____

3. What percentage of your pain management practice is:

   Terminal _____ Non-Terminal _____ Both _____

4. Are you ACLS certified? ☐ Yes ☐ No

   If not, is someone in the immediate area of your procedures ACLS certified? ☐ Yes ☐ No

5. List all facilities in which you do pain management procedures:

   _____

   _____

   Of those facilities that are not JCAHO accredited, please define how privileges are granted and how these records are maintained.

   _____

   _____

6. Do you require patients to whom you prescribe controlled substances for chronic pain to sign an agreement or contract stipulating indications and risk for these medications and consequences of violating the agreement? ☐ Yes ☐ No

7. If you do any investigative or experimental procedures, please provide the name and address of the responsible granting or oversight committee:

   _____

   _____

8. Are you in a group? ☐ Yes ☐ No

   Group name: _____

   Do you practice only with other pain management physicians? ☐ Yes ☐ No

With what other specialties do you practice? _____

9. Does your group have a credentialing process for the practice of pain management? ☐ Yes ☐ No

10. What percentage of your practice is pain management? _____%

11. Do you require your pain management patients to have an attending or primary care physician? ☐ Yes ☐ No

12. Does your pain management practice have a Ph.D. Clinical Psychologist associated with it, and what percentage of patients are referred to him/her? ☐ Yes ☐ No Percentage: _____%

13. When prescribing opioids for non-malignant pain, do you require an evaluation by a Psychiatrist or a Ph.D. Clinical Psychologist? ☐ Yes ☐ No

14. What procedures and or modalities do you use in your practice? (Circle all that apply, list others)

Level I	Level II	Level III
Corticosteroid injections	Neuroablative techniques	Spinal Epiduroscopy/Myeloscopy
Neural blockades	Neurostimulation therapy	Implanted devices-please list
Trigger point injections	Opioid Therapy	Spinal Cord Stimulator Trials
How many?(12 mo.)_____		Spinal Cord Stimulators
In Neck or Spine? ☐Yes ☐ No		
Adjuvant analgesics		_____
Epidurals		
How many?(12 mo.)_____		

Others (please list): _____

15. What ancillary therapies are used in your pain management practice? (Check all that apply)

☐Physical Therapy ☐Occupational Therapy ☐Psychological Therapy ☐Acupuncture

16. Do you perform Epidural Steroid Injections (ESI)? ☐ Yes ☐ No

17. Do you perform Discography? ☐ Yes ☐ No

18. Do you prescribe or dispense controlled substances as defined by the Controlled Substances Act? ☐ Yes ☐ No If "yes", please describe, including percent of practice.

_____
_____
_____

19. Please specify any procedures not listed above for which you wish to be insured:

_____
_____
_____

_____ _____
Physician's Signature Date

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PAIN MANAGEMENT PROCEDURE QUESTIONNAIRE

NAME: _____

Please check either "YES" or "NO" for every procedure to indicate whether you plan to perform any of the following procedures in your current practice:

ACUPUNCTURE	☐ YES	☐ NO
BLOCKS:		
CAUDAL EPIDURAL BLOCK	☐ YES	☐ NO
CELIAC PLEXUS BLOCK	☐ YES	☐ NO
CERVICAL EPIDURAL	☐ YES	☐ NO
DIFFERENTIAL SPINAL	☐ YES	☐ NO
FACET JOINT BLOCK:		
CERVICAL	☐ YES	☐ NO
LUMBAR	☐ YES	☐ NO
THORACIC	☐ YES	☐ NO
LUMBAR EPIDURAL	☐ YES	☐ NO
LUMBAR SYMPATHETIC BLOCK	☐ YES	☐ NO
PERIPHERAL NERVE BLOCK	☐ YES	☐ NO
RETROBULBAR BLOCK	☐ YES	☐ NO
SPINAL NERVE BLOCK	☐ YES	☐ NO
STELLATE GANGLION BLOCK	☐ YES	☐ NO
SYMPATHETIC NERVE BLOCK	☐ YES	☐ NO
BOTOX INJECTIONS	☐ YES	☐ NO
CERVICAL DISCOGRAMS	☐ YES	☐ NO
CERVICAL DISC NUCLEOPLASTY	☐ YES	☐ NO
CORDOTOMIES	☐ YES	☐ NO
CRYOANALGESIA	☐ YES	☐ NO
DORSAL COLUMN STIMULATOR IMPLANTS/REPROGRAM	☐ YES	☐ NO
EPIDURAL OR SPINAL CATHETERS	☐ YES	☐ NO
FLUOROSCOPY	☐ YES	☐ NO
INTRA-ARTICULAR BLOCK (JOINT INJECTIONS)	☐ YES	☐ NO

INTRADISCAL ELECTROTHERMAL THERAPY	☐ YES	☐ NO
INTRAVENOUS REGIONAL ANESTHESIA	☐ YES	☐ NO
HYPNOSIS	☐ YES	☐ NO
LUMBAR DISCOGRAMS	☐ YES	☐ NO
LUMBAR DISC NUCLEOPLASTY	☐ YES	☐ NO
MANIPULATION UNDER ANESTHESIA	☐ YES	☐ NO
MYOFASCIAL TRIGGER POINT INJECTIONS	☐ YES	☐ NO
NERVE ROOT INJECTIONS	☐ YES	☐ NO
PERCUTANEOUS DISCECTOMY	☐ YES	☐ NO
PERCUTANEOUS ENDOSCOPIC NERVE ROOT DECOMPRESSION	☐ YES	☐ NO
PERIPHERAL NERVE STIMULATION	☐ YES	☐ NO
PHYSICAL THERAPY	☐ YES	☐ NO
PROLOTHERAPY	☐ YES	☐ NO
If "YES", do you use Phenol? ☐ YES ☐ NO		
RADIO FREQUENCY NERVE ABLATION	☐ YES	☐ NO
RAPID DETOXIFICATION	☐ YES	☐ NO
SPHENOPALATINE LESIONING	☐ YES	☐ NO
SPINAL INFUSION IMPLANTS OR REMOVAL	☐ YES	☐ NO
SPINAL INFUSION PUMPS REFILLING & REPROGRAMMING	☐ YES	☐ NO
SPINAL STIMULATION IMPLANTS	☐ YES	☐ NO
SPINAL STIMULATION PROGRAMMING	☐ YES	☐ NO
THORACIC SYMPATHECTOMIES	☐ YES	☐ NO
TRIGEMINAL LESIONING	☐ YES	☐ NO
VERTEBROPLASTY	☐ YES	☐ NO

What percentage of your practice incorporates the procedures above?_____

Where (which locations) is the insured practicing this type of surgery?_____

_____

Please list other procedures you perform that are not listed above:

_____

_____

Please provide proof of training/certification with an approved anesthesia program to the procedures that you have indicated above.

Signature _____ Date: _____