

Marla D. Golden, D.O., PA
6817 Southpoint Parkway, Suite 1404
Jacksonville, FL 32216
(904) 260-1070 Office | (904) 260-1170 Fax

Patient Demographic and Insurance Intake Form

Last Name: _____ First Name: _____ MI: _____

DOB: _____ SS#: _____ Sex: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____ @ _____ Referred by: _____

Primary Care Physician Name and Phone: _____

Pharmacy Name and Phone: _____

Insurance Information

Primary Insurance Co: _____ ID #: _____ Grp #: _____

Secondary Insurance Co: _____ ID #: _____ Grp #: _____

Policy Holder name: _____ ID #: _____

Policy Holder DOB: _____ Policy Holder Address: _____

Policy Holder SS #: _____ Policy Holder Sex: _____ Copay Amount: _____

Patient Authorization

I authorize the release of any medical information necessary to process any claim. I authorize payment of medical benefits to the physician for services rendered.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if minor): _____ Date: _____

Managed Care / HMO Patients

I understand that it is my responsibility to obtain a valid referral from my primary care physician. I understand that if I do not obtain or have a referral on file that I may be held financially responsible for services received. I further understand that I am responsible for services that are considered non-covered expenses by my insurer.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if minor): _____ Date: _____

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Today's Date: _____

Dear New Patient:

Welcome to the practice! I am looking forward to seeing you and working with you to relieve your pain. We are one of the only practices worldwide targeting the brain as an organ of treatment to combat and relieve pain.

The treatment plan at Marla D. Golden, D.O., PA features the Neuroplastic Transformation program created by me and Dr. Michael Moskowitz. It is based on the core concept of neuroplasticity and the body's ability to change in response to the input it receives. You will be guided through phases of care designed to restore function and allow you to return to a pleasurable life. The emphasis of treatment options will change as you move through the phases.

Please read this letter carefully and be sure you are willing to comply with the following requests:

Please arrive 30 minutes prior to your appointment time and plan to be here an additional 75-90 minutes. Please be considerate of my time and that of other scheduled patients. A 48 to 74 hour notice of cancellation or rescheduling of a new patient appointment is required. A 24 hour notice is required for a follow up visit. A message left on the voicemail the night before does not constitute a 24 hour notice of cancellation.

Please have your medical records sent to us prior to your first visit. Your treating physician can forward your records at your request. These include copies of recent office visit notes of treating physicians, reports of diagnostic studies, x-rays, CT scans, MRI's, ultrasounds and any pertinent lab work prior to your first visit.

You are required to have a primary care physician to manage your basic medical care. I will be providing your pain care. It is my preference to send office visit notes to your primary care physician to keep them informed of your progress. Many patients have additional members of their Pain Care Team. These may include psychiatrists, physical therapists, as well as other types of practitioners in addition to your primary care physician. You have the right to decide who is kept informed; however, a team approach is always beneficial. We can discuss this further at your first visit. Please submit the names and phone numbers of all treating physicians or health care professionals that are part of your pain care team with this paperwork.

Medication regimens will be reviewed at the first visit and throughout treatment. As a general rule, controlled substances are not prescribed at the first visit. We will discuss the role of medications in the different phases of care and use N.O.R.M.A.L., the Neuroplastic Optimization and Reduction of Medications for Adaptive Living.

Urine drug screening may be done at my discretion. The purpose is to monitor medication changes, disconcerting signs or symptoms associated with medications, and to determine how medications are being taken.

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Please bring all of your pain-related medications, and medication list to each appointment. Please bring insurance card(s), a picture ID, and any applicable copayment with you to your initial appointment and to any appointment after a change of information has been made.

If you have any questions or concerns prior to your first appointment, please feel free to call the office. My staff will be happy to answer questions of any kind. If you have any further concerns, I will be happy to discuss them at your initial visit. I am hopeful that we will enjoy an open and honest physician-patient relationship. This is critical to the success of your overall pain care program.

Once again, I am happy to welcome you to the practice and look forward to meeting you.

Sincerely,

Marla D. Golden, D.O. FACEP
Director
Electronically reviewed and signed

Your appointment has been scheduled for _____ at _____.

Please be sure to call the office with your insurance information prior to your first appointment.

Thank you!

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Marla D. Golden, D.O., PA Office Policies & Procedures

Please read the following statements, initial by each and sign the sheet after you have gone over each of them.

BILLING AND INSURANCE

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize; however, that your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

Most insurance companies consider our fees usual, customary, and reasonable. If your insurance company does not cover the whole fee, the balance becomes your responsibility.

_____ Payment for office services is due at the time services are rendered unless we participate with your insurance plan or payment arrangements have been approved in advance by our staff. We accept cash, checks, Visa and Master Card. If we participate with your insurance carrier, we expect applicable co-payment and deductibles at the time of service.

_____ A \$30.00 fee will be charged for returned checks. Repayment of original fee plus returned check fee is due prior to the next office visit by cash, credit card, money order or cashier's check.

_____ I understand all services are not covered by all contracts and I am responsible for uncovered services.

_____ If you have health insurance that has a timely filing limit and you do not provide this information prior to that deadline, the responsibility for the medical debt is yours, regardless of what your insurance tells you.

_____ **I understand it is my responsibility to provide the correct insurance information, whether it be a change in insurance carrier or policy, *prior to my next scheduled appointment*. Failure to inform the office of any changes can result in denial of payment by my insurance company and any charges will be my responsibility.**

_____ If your health insurance sends you their payment, you are required to remit the payment to Dr. Golden immediately.

_____ If you are being seen for a work related injury, we must have the date of injury, W/C carrier name and address, the claim number assigned to your case and the adjusters name and phone number. The office will verify this information with the carrier. If the carrier says your employer did not report your injury, you will not be seen by Dr. Golden under workers compensation insurance.

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BILLING AND INSURANCE (CONTINUED)

_____ If you are being seen for injuries related to an auto accident, we will need the date of the accident, the claim number assigned by your auto insurance company, the adjusters name and phone number assigned to your claim and the address where claims should be mailed. If you are unable to furnish this information, you may reschedule your appointment or pay for the charges at the time of service. It is the responsibility of the patient to provide all insurance information. The office will verify the information given. If you have a high deductible and it has not been met, you will be required to pay that amount prior to being seen. Dr. Golden DOES NOT accept Letters of Protection.

_____ If you are being seen for an injury that is a result of a fall or injury that is a liability case, you must inform us prior to being seen and you must pay the medical debt in full. Dr. Golden does not file liability claims. You can take the receipt for the medical treatment and give that receipt to the person handling your liability case and they will reimburse you.

_____ If you do not have health insurance, payment is due in full at the time of service.

_____ Patients will not be able to carry a balance on their account over 30 days. Once your insurance carrier has processed the claim, and determined that the patient has a financial responsibility, you will receive a statement from our office. Statements are mailed once a month and payment is due upon receipt or by your next office visit, whichever comes first. Delinquent accounts over 90 days and 3 statements with failed attempts to collect unpaid balances will be turned over to a collection agency. You will be responsible for any administrative/collection fees and legal costs that are incurred.

APPOINTMENTS

_____ You are expected to arrive for your appointment on time. It is even advisable to be a few minutes early to update any necessary information and address any payment issues prior to being seen.

_____ Monday appointments must be cancelled by 2 PM on Friday **PRIOR** to the weekend or a \$50.00 late cancellation fee will be charged.

_____ Tuesday through Friday appointments require a 24-hour notice of **CANCELLATION** to avoid a \$35.00 late cancellation fee.

_____ Stand-alone NMT appointment cancellations or no shows will be charged in the same fashion as the above.

_____ Cancellations sent via text message, or email will not be accepted and will be considered a No-Show, and a No Show fee will be charged.

_____ New patient's that do not show for scheduled appointments will be rescheduled once.

_____ More than 2 late cancellations or no shows may result in discharge from the practice.

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MESSAGES/EMERGENCIES/AFTER HOURS CALLS

_____ If you have concerns after hours, call the office, you will be able to leave a message that will be checked the next business day. If there is an emergency, call 911. My cell phone is available for **URGENT** telephone communication **AFTER HOURS**. It should not be used for non-urgent matters. It should not be used during normal business hours. Scheduling and rescheduling requests or clinical communication is done by phone conversation via office phone during normal business hours. **DO NOT** text or e-mail me clinical questions or information or scheduling requests.

_____ I am available by cell phone if you are being treated in the emergency department or are hospitalized. Please feel free to give my number to treating physicians should they need to coordinate care.

_____ **DO NOT** e-mail or fax the office about clinical concerns, appointments or medications. Email is not protected for privacy. Fax communications can be unreliable. They may not get through or may be delayed on either end. *(All such e-mails or faxes that were previously acknowledged will be no longer).*

_____ Voicemail is checked hourly on workdays, when the office is open. You will have **PLENTY of** advance notice of any office closures. All calls are returned to patients in order of clinical acuity. When you leave a message, please specify whether or not you require a return phone call. Expect telephone conversations to be brief and to the point.

_____ You will be charged a \$50.00 fee per 15 minutes for non-urgent phone conversations with Dr. Golden.

_____ Urgent matters should be able to be resolved in 15 minutes. Extended conversations will be charged \$50.00 per 15 minutes after the 1st 15 minutes.

_____ Dr. Golden does not answer the office phone. Please direct all questions and concerns to the office personnel, they will communicate with me and get back to you. If necessary, Dr. Golden will call you directly.

PRESCRIPTIONS AND MEDICATIONS

_____ State law requires patients on controlled substances to be seen every 3 months. **NO** medications will be prescribed if you have not been seen in SIX months. Your chart will be closed and in order to reopen it you will need to schedule an extended time visit and interim medical records will be required.

_____ Medications are prescribed and refilled at office visits. Please know what is needed when you come in for your appointment.

_____ If you send someone else to pick up your prescription, this person must be listed on the Release of Information form you signed. This person also must show valid proof of identification in order to pick up your prescription.

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PRESCRIPTIONS AND MEDICATIONS (CONTINUED)

_____ If refills are necessary at times other than office visits, please allow **THREE** business days for refills to be processed. Remember, we try to avoid this as much as possible and refill medications at office visits.

_____ There is **NO** guarantee urgent demands for refills that are made inside this three-day window will be met.

_____ **ALL** fees must be paid, or payment plans must have been set up through our office prior to any prescription(s) being called in, refilled or provided.

_____ Patients who misuse or overuse medications will be referred to the appropriate practitioner or law enforcement agency at Dr. Golden's discretion and per controlled substance agreement.

MISCELLANEOUS

_____ Please make sure your contact information is current and correct. It is your responsibility to notify us of any changes.

_____ If someone calls our office to inquire about you and this person is not listed on your Release of Information form, **NO** information will be released regardless of your relationship to this person. We will neither confirm nor deny that you are a patient in this practice.

_____ Office staff must be treated with courtesy and respect. Failure to do so will most likely result in discharge from the practice.

If you have a complaint about our office, please provide me/us with specific date, time, employee or service in question. I cannot operate on generalities.

I hereby attest that I have read and understand the information provided to me regarding the Policies and Procedures of Marla D. Golden, D.O., PA and agree to abide by these terms and conditions.

Signature: _____ Date: _____

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Controlled Substance Policy Information Consent

As part of your treatment with Dr. Golden, you may need a prescription to control your pain. These medications can include narcotics (painkillers) and sedative/hypnotic (anti-anxiety/sleeping pills). These medications are called controlled substances. They are monitored closely by the Drug Enforcement Agency in Washington, D.C.

Therefore, we have a strict set of rules you must follow while under our care using these medications.

Please read the following statements, initial by each and sign the sheet after you have gone over each of them.

_____ I agree to bring in all of my medications to every visit. This includes all pill bottles, pills, daily dose packs, and pill containers of any kind. This policy is to ensure your safety when prescribing medications.

_____ I agree to never share or sell any of my medications.

_____ I understand and agree that I am fully responsible for all my medications.

_____ I agree never to obtain additional pain medications from any other Healthcare Provider including my Primary Care Provider unless I get approval from Dr. Golden.

_____ I agree to fill my prescriptions with only one pharmacy, if possible. I will make Dr. Golden or Marla D. Golden, DO staff aware of pharmacy issues.

_____ I agree never to increase my dose prior to discussing this with Dr. Golden. I understand no early refills will be provided if I escalate my medication use without prior approval.

_____ I understand that there exists a risk of developing an addictive behavior with many of these drugs, although this behavior is a rare occurrence, it still can happen. I agree to discuss any craving or compulsive use of medications with Dr. Golden as soon as it occurs.

_____ I understand that if my medications are stolen, I will report to my local police department within 24 hours and prior to Dr. Golden prescribing another refill. I agree to obtain a stolen/missing item report from the police. More than one lost or stolen medication occurrence is considered irresponsible behavior and will result in discharge from our practice.

_____ I understand that Marla D. Golden, D.O., PA may conduct random quarterly drug screens on all patients. Drug screens may also be conducted with medication changes, disconcerting signs or symptoms associated with medications, or at Dr. Golden's discretion.

_____ I understand and agree that due to the seriousness of these medications, Dr. Golden will **NEVER** be able to phone in any refills. All prescriptions will be given out at office visits only. **NO EXCEPTIONS.**

_____ I understand that I waive all rights to HIPAA regulations if found in violation of any controlled substance act with respect to illicit or prescription drug use, abuse or diversion.

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Controlled Substance Policy Information Consent

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_____ I understand that any and all violations of the controlled substance acts with respect to illicit or prescription drug use, abuse or diversion will be handed over to law enforcement to take the necessary and proper steps to investigate.

_____ I have read and understand the above policy and by signing this form, I agree to follow these rules.

_____ I understand that any breach in any rule are grounds to be discharged from the practice formally by a written letter; as well as, personally contacting your primary care physician or referring physician.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

Pharmacy: _____ Phone: _____

Name: _____ Date: _____

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Marla D. Golden, D.O., PA, for purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Marla D. Golden, D.O., PA.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. However, if Marla D. Golden, D.O., PA agrees to the restrictions that I request, the restriction is binding on Marla D. Golden, D.O., PA. I have the right to revoke this consent, in writing, at any time, except to the extent that Marla D. Golden, D.O., PA have taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider or hospital (including all departments of such), a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have reviewed Marla D. Golden, D.O., PA Notice of Privacy Practices prior to signing this document. The Marla D. Golden, D.O., PA Notice of Privacy Practices was provided to me. It is also posted in the waiting room for my information. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Marla D. Golden, D.O., PA. The Notice of Privacy Practices also describes my and Marla D. Golden, D.O., PA duties with respect to my protected health information. Marla D. Golden, D.O., PA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Rep. Auth.

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ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT

Necessary forms will be completed to help expedite insurance reimbursement. However, unless we participate with your insurance company, the patient is responsible for all fees regardless of insurance coverage. Patients with insurance with which we participate are responsible for all co-insurance, co-pays, deductibles and non-covered services. Co-pays are due at the time of service, unless other arrangements have been made in advance with our office.

Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

RELEASE OF INFORMATION

- I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:
- Spouse: _____
 - Child(ren): _____
 - Other: _____
- Information is **not** to be released to anyone other than the patient.

This **Release of Information** will remain in effect until terminated by me in writing.

MESSAGES

Please call my home my work my cell Telephone Number: _____

If unable to reach me:

- You may leave a detailed message
- Please leave a message asking me to return your call
- _____

The best time to reach me is (day) _____ between (time) _____.

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Insurance Authorization and Assignment of Benefits

I request that payment or authorized Medicare/Other insurance company benefits be made on my behalf to Marla D. Golden, D.O. for any services furnished to me by Marla D. Golden, D.O. I authorize any holder of medical information about me to release to the Centers of Medicare & Medicaid services (CMS) and its agents/Other insurance companies any information needed to determine the benefits payable to related services.

I understand my signature requests that payments be made and authorize release of medical information necessary to pay any claims.

Signature: _____

Date: _____

Witness: _____

Date: _____

Patient History

PATIENT NAME: _____

DATE: _____

PLEASE CHECK ALL THAT APPLY

- ____ Stroke
- ____ Hypertension
- ____ Arrhythmia
- ____ Heart Attack/MI

- ____ Mitral Valve Prolapse
- ____ Pacemaker
- ____ Emphysema/COPD
- ____ Pneumonia
- ____ Seizures
- ____ Depression
- ____ Meningitis/Encephalitis
- ____ Bipolar Disorder
- ____ Hepatitis Type: _____
- ____ Cirrhosis
- ____ Cancer: _____
- ____ Ulcer Disease
- ____ GERD (acid reflux/heartburn)

- ____ Hiatal Hernia
- ____ Inflammatory Bowel Disorder
- ____ Crohn's Disease
- ____ Osteoarthritis
- ____ Rheumatoid Arthritis
- ____ Diabetes
- ____ Lupus/Scleroderma
- ____ Hypothyroid/Graves
- ____ Crohn's Disease

PREVIOUS PAIN MANAGEMENT

- ____ Massage
- ____ Biofeedback
- ____ Injections
- ____ Physical Therapy
- ____ Chiropractor
- ____ Acupuncture

- Prostate Problems _____
- Interstitial Cystitis _____
- Endometriosis _____
- Peripheral Vascular Disease _____
- Blood Clots/Location: _____
- Fibromyalgia _____
- Kidney Disease _____
- Neuropathy _____
- CRPS/(RSD) _____
- Other: _____

SOCIAL HISTORY

- Tobacco ____ PPD ____ Years ____
- Alcohol ____ Type ____ Amt ____ Yrs ____
- Recreational Drugs ____ Type ____ Yrs ____

- Current Occupation _____
- Partially Disabled ____ % ____
- Totally Disabled _____
- Pre-Disability Occupation _____
- Living Situation _____

FAMILY HISTORY

- _____
- _____
- _____
- _____

PERTINENT SURGICAL HISTORY

- _____
- _____
- _____
- _____

ALLERGIES: _____

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The Drug Abuse Screening Test (DAST)

PATIENT NAME: _____

DATE: _____

Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

	YES	NO
1. Have you used drugs other than those required for medical reasons?	___	___
2. Have you abused prescription drugs?	___	___
3. Do you abuse more than one drug at a time?	___	___
4. Can you get through the week without using drugs (other than those required for medical reasons)?	___	___
5. Are you always able to stop using drugs when you want to?	___	___
6. Do you abuse drugs on a continuous basis?	___	___
7. Do you try to limit your drug use to certain situations?	___	___
8. Have you had "blackouts" or "flashbacks" as a result of drug use?	___	___
9. Do you ever feel bad about your drug abuse?	___	___
10. Does your spouse (or parents) ever complain about your involvement with drugs?	___	___
11. Do your friends or relatives know or suspect you abuse drugs?	___	___
12. Has drug abuse ever created problems between you and your spouse?	___	___
13. Has any family member ever sought help for problems related to your drug use?	___	___
14. Have you ever lost friends because of your use of drugs?	___	___
15. Have you ever neglected your family or missed work because of your use of drugs?	___	___
16. Have you ever been in trouble at work because of drug abuse?	___	___
17. Have you ever lost a job because of drug abuse?	___	___
18. Have you gotten into fights when under the influence of drugs?	___	___
19. Have you ever been arrested while under the influence of drugs?	___	___
20. Have you ever been arrested for driving while under the influence of drugs?	___	___
21. Have you engaged in illegal activities in order to obtain drug?	___	___
22. Have you ever been arrested for possession of illegal drugs?	___	___
23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	___	___
24. Have you had medical problems as a result of your drug use?	___	___
25. Have you ever gone to anyone for help for a drug problem?	___	___
26. Have you ever been in a hospital for medical problems related to your drug use?	___	___
27. Have you ever been involved in a treatment program specifically related to drug use?	___	___
28. Have you been treated as an outpatient for problems related to drug abuse?	___	___

Scoring and interpretation: A score of "1" is given for each YES response, except for items 4,5, and 7, for which a NO response is given a score of "1." Based on data from a heterogeneous psychiatric patient population, cutoff scores of 6 through 11 are considered to be optimal for screening for substance use disorders. Using a cutoff score of 6 has been found to provide excellent sensitivity for identifying patients with substance use disorders as well as satisfactory specificity (i.e., identification of patients who do not have substance use disorders). Using a cutoff score of <11 somewhat reduces the sensitivity for identifying patients with substance use disorders, but more accurately identifies the patients who do not have a substance use disorders. Over 12 is definitely a substance abuse problem. In a heterogeneous psychiatric patient population, most items have been shown to correlate at least moderately well with the total scale scores. The items that correlate poorly with the total scale scores appear to be items 4,7,16,20, and 22.

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CAGE Questionnaire

PATIENT NAME: _____

DATE: _____

• Have you ever felt you should **C**ut down on your drinking?

• Have people **A**nnoyed you by criticizing your drinking?

• Have you ever felt bad or **G**uilty about your drinking?

• Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)?

Scoring:

Item responses on the CAGE are scored 0 or 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.

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Developed by Dr. John Ewing, founding Director of the Bowles Center for Alcohol Studies, University of North Carolina at Chapel Hill, CAGE is an internationally used assessment instrument for identifying alcoholics. It is particularly popular with primary care givers. CAGE has been translated into several languages.

The CAGE questions can be used in the clinical setting using informal phrasing. It has been demonstrated that they are most effective when used as part of a general health history and should NOT be preceded by questions about how much or how frequently the patient drinks (see "Alcoholism: The Keys to the CAGE" by DL Steinweg and H Worth; American Journal of Medicine 94: 520-523, May 1993.

The exact wording that can be used in research studies can be found in: JA Ewing "Detecting Alcoholism: The CAGE Questionnaire" JAMA 252: 1905-1907, 1984. Researchers and clinicians who are publishing studies using the CAGE Questionnaire should cite the above reference. No other permission is necessary unless it is used in any profit-making endeavor in which case this Center would require to negotiate a payment.

.....
012695 (02-2004)

Source: Dr. John Ewing, founding Director of the Bowles Center for Alcohol Studies, University of North Carolina at Chapel Hill

Michigan Alcoholism Screening Test (MAST)

PATIENT NAME: _____

DATE: _____

The MAST Test is a simple, self-scoring test that helps assess if you have a drinking problem. Please answer YES or NO to the following questions:

MICHIGAN ALCOHOLISM SCREENING TEST (MAST)

	YES	NO	Points
0. Do you enjoy drinking now and then?	___	___	
* 1. Do you feel you are a normal drinker? ("normal" - drink as much or less than most other people)	___	___	(2)
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	___	___	(2)
3. Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?	___	___	(1)
* 4. Can you stop drinking without a struggle after one or two drinks?	___	___	(2)
5. Do you ever feel guilty about your drinking?	___	___	(1)
* 6. Do friends or relatives think you are a normal drinker?	___	___	(2)
* 7. Are you able to stop drinking when you want to?	___	___	(2)
8. Have you ever attended a meeting of Alcoholics Anonymous (AA)?	___	___	(5)
9. Have you gotten into physical fights when drinking?	___	___	(1)
10. Has your drinking ever created problems between you and your wife, husband, a parent, or other relative?	___	___	(2)
11. Has your wife, husband (or other family members) ever gone to anyone for help about your drinking?	___	___	(2)
12. Have you ever lost friends because of your drinking?	___	___	(2)
13. Have you ever gotten into trouble at work or school because of drinking?	___	___	(2)
14. Have you ever lost a job because of drinking?	___	___	(2)
15. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?	___	___	(2)
16. Do you drink before noon fairly often?	___	___	(1)
17. Have you ever been told you have liver trouble? Cirrhosis?	___	___	(2)
** 18. After heavy drinking have you ever had Delirium Tremens (D.T.s) or severe shaking, or heard voices, or seen things that are really not there?	___	___	(2)
19. Have you ever gone to anyone for help about your drinking?	___	___	(5)
20. Have you ever been in a hospital because of drinking?	___	___	(5)
21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization?	___	___	(2)
22. Have you ever been seen at a psychiatric or mental health clinic or gone to any doctor, social worker, or clergyman for help with any emotional problem, where drinking was part of the problem?	___	___	(2)
*** 23. Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? (If YES, How many times?___)	___	___	(2)
*** 24. Have you ever been arrested, or taken into custody even for a few hours, because of other drunk behavior? (If YES, How many times?___)	___	___	(2)

SCORING

Add up the points for every question you answered with YES, for Q23 and Q24 multiply the number of times by points

0 - 3 No apparent problem

4 Early or middle problem drinker

5 or more Problem drinker (Alcoholic)

References

Selzer, M.L., *The Michigan Alcoholism Screening Test (MAST): The Quest for a New Diagnostic Instrument. American Journal of Psychiatry*, 3:176-181, 1971.

Selzer, M.L., Vinokur, A., and van Rooijen, L., *Self-Administered Short Version of the Michigan Alcoholism Screening Test (SMAST). Journal of Studies on Alcohol*, 36:117-126, 1975

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Opioid Risk Tool (ORT)

PATIENT NAME: _____

DATE: _____

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse. Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk tool. Pain Med. 2005; 6 (6) : 432