New Jersey

SPINE & PAIN INSTITUTE

Joseph Ibrahim, MD, FAAPMR

NEW PATIENT INTAKE FORM

First Name: _____ **Last Name:** _____

DOB: __/__/____ **SSN:** _____-_____-_____ **Age:** _____ **Sex:** M F

Marital Status: S M W D **Height:** _____ **Weight:** _____

Address: _____ **City/State:** _____ **Zip:** _____

Phone #: (___) ___-_____ **Cell #:** (___) ___-_____ **Email:** _____

Occupation: _____ **Employer:** _____

Please circle for the following questions:

Race: White / Black / Hispanic / American Indian / Alaska Native / Asian / African American / Native Hawaiian /Other
Ethnicity: Hispanic / Latino / Not Hispanic / Not Latino / Other
Language: English / Spanish / Italian / French / German / Chinese / Arabic / Other

Emergency Contact: _____ **Relation:** _____ **Phone #** (___) ___-_____

PCP: _____ **Phone:** _____ **Address:** _____

Referring MD: _____ **Phone:** _____ **Address:** _____

Pharmacy: _____ **Phone:** _____ **Address:** _____

How did you hear about our office? Doctor/Attorney/Friend/Internet
Is your pain related to **a work injury / motor vehicle accident / other?**

INSURANCE INFORMATION

(If your pain was caused by an accident please use that information as your primary insurance)

	Primary Insurance	Secondary Insurance
Company :	_____	_____
Card Holder:	**Name:** _____	**Name:** _____
Card Holder:	**DOB:** __/__/____	**DOB:** __/__/____
Policy #:	_____	_____
Group #:	_____	_____

Date of Accident: ____/____/____ **Claim #:** _____
Attorney: _____ **Phone #:** _____ **Fax #:** _____
Adjuster: _____ **Phone #:** _____ **Fax #:** _____
Claim Rep: _____ **Phone #:** _____ **Fax #:** _____

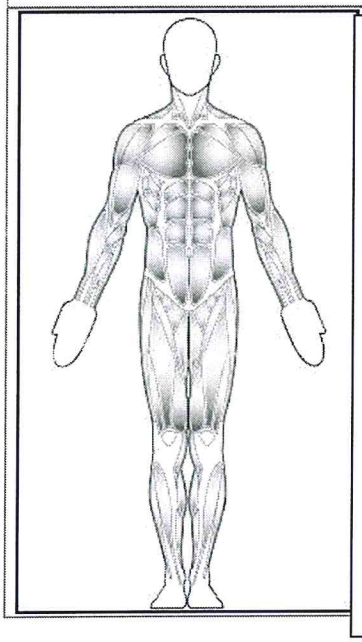
JOSEPH G.A. IBRAHIM, M.D., F.A.A.P.M.R.
Interventional Spine and Pain Management
Diplomat American Board of Physical Medicine & Rehabilitation
Diplomat American Board of Pain Medicine

Hospital Affiliations:
St. Clare's Health System, Denville, NJ
Bayonne Medical Center, Bayonne, NJ
Christ Hospital, Jersey City, NJ
Hoboken Medical Center, Hoboken, NJ
Newark Beth Israel Medical Center, Newark, NJ

MEDICAL INTAKE FORM

Patient NAME: _____ **DOB:** _____

CHIEF COMPLAINT / REGION OF PAIN	Associated Signs and Symptoms of Pain	
1) _____	☐ Sleeping _____	☐ Hip Pain _____
2) _____	☐ Headache _____	☐ Migraine _____
3) _____	☐ Joint Pain/Stiffness _____	☐ Knee Pain _____
4) _____	☐ Numbness _____	☐ Other _____



SEVERITY OF PAIN

List region of pain and circle severity number.
(1 = least, 10 = greatest)

MARK PAIN REGION

Burning _ Stabbing Sharp _ Constant

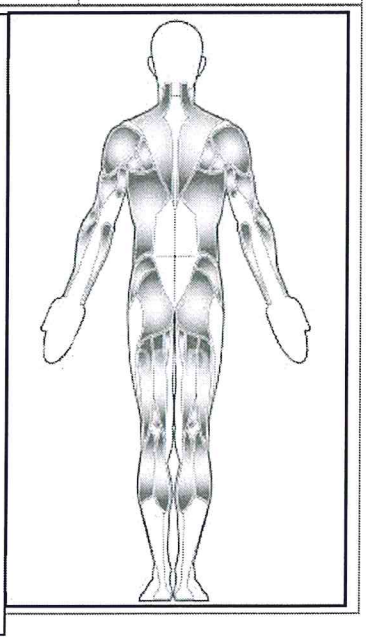
Mark Pain Area

+++	Burning
000	Stabbing
---	Sharp
!!!	Constant
xxx	Other

Regions

Neck	1	2	3	4	5	6	7	8	9	10
Mid Back	1	2	3	4	5	6	7	8	9	10
Lower Back	1	2	3	4	5	6	7	8	9	10
Hips	1	2	3	4	5	6	7	8	9	10
Arms	1	2	3	4	5	6	7	8	9	10
Legs	1	2	3	4	5	6	7	8	9	10

Please mark the pain area on the drawing using the code listed above.



How long have you had pain: _____ **When is your pain worst:** _____
(day, evening, bedtime)

If you have neck pain, which percentage of your pain is neck _____ **and arm** _____**(total 100%)**
If you have back pain, which percentage of your pain is back _____ **and leg** _____ **(total 100%)**

Questions about your pain: Please check which of the items below you have had for your pain)

_____Chiropractor	_____TENS	_____Epidural	_____ Neurology Consult
_____Physical Therapy	_____Brace	_____Other procedure	_____ Anti-inflammatory
_____Acupuncture	_____MUA	_____Surgery	_____ Narcotic
_____X-ray	_____MRI	_____Orthopedic Consult	_____ Muscle relaxant
_____ EMG	_____CT Scan	_____Surgical Consult	_____ Antidepressant

Check the position that makes your pain worst:

Position	Worse	Better	Comments
Bending			
Bowel Movement			
Coughing			
General Activity			
Home Remedies			
Lying Down			
Sitting			
Standing			
Walking			

How long can you STAND with no or minimal pain _____minutes

How far can you walk with NO or MINIMAL pain?

0-50FT_____ 50-200FT_____ 200-500FT_____ 500FT+_____ ½ Mile + _____

Do you need support to help you walk? ( ) Yes ( ) No

If yes, what type of support? _____

Do you wear a back or neck brace? ( ) Yes ( ) No

If yes, what type of brace? _____

REVIEW OF SYSTEMS

Musculoskeletal:

Arthritis	☐ Yes	☐ No	Joint Pain	☐ Yes	☐ No	Gout	☐ Yes	☐ No
Back Problem	☐ Yes	☐ No	Deformities	☐ Yes	☐ No	Paralysis	☐ Yes	☐ No
Joint Stiffness	☐ Yes	☐ No	Muscle Cramps	☐ Yes	☐ No	Weakness	☐ Yes	☐ No
Restricted Motion	☐ Yes	☐ No	Muscle Stiffness	☐ Yes	☐ No			

Neurological:

Blackouts	☐ Yes	☐ No	Paralysis	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Fainting	☐ Yes	☐ No	Head Injury	☐ Yes	☐ No	Migraines	☐ Yes	☐ No
Numbness	☐ Yes	☐ No	Tremors	☐ Yes	☐ No	Dizziness	☐ Yes	☐ No
Tingling	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Burning	☐ Yes	☐ No

REVIEW OF SYSTEMS

Constitutional:

Chills	☐ Yes	☐ No	Fever	☐ Yes	☐ No	Decline in Health	☐ Yes	☐ No
Weakness	☐ Yes	☐ No	Fatigue	☐ Yes	☐ No	Weight Gain	☐ Yes	☐ No
Itchiness	☐ Yes	☐ No	Weight Loss	☐ Yes	☐ No			

Head:

Dizziness	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Head Injury	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Pain	☐ Yes	☐ No	Sweats	☐ Yes	☐ No

Eyes:

Blurry Vision	☐ Yes	☐ No	Cataracts	☐ Yes	☐ No	Discharge	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No	Excessive Tearing	☐ Yes	☐ No	Eye Pain	☐ Yes	☐ No

Respiratory:

Asthma	☐ Yes	☐ No	Cough	☐ Yes	☐ No	Wheezing	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Cough Blood	☐ Yes	☐ No	Pain	☐ Yes	☐ No
Pleaurisy	☐ Yes	☐ No	Positive TB Test	☐ Yes	☐ No	Chest X-Ray	☐ Yes	☐ No
Short of Breath	☐ Yes	☐ No	Sputum	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No

Heart:

Chest Pain	☐ Yes	☐ No	Palpitations	☐ Yes	☐ No
Varicose Vein	☐ Yes	☐ No	Extremity(s) Cool	☐ Yes	☐ No
Extremity(s) Discolored	☐ Yes	☐ No	Hair Loss on Legs	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Heart Test (not EKG)	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No			

Stomach:

Abdominal Pain	☐ Yes	☐ No	Constipation	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No
Vomiting Blood	☐ Yes	☐ No	Nausea	☐ Yes	☐ No	Rectal Pain	☐ Yes	☐ No
Swallowing Problem	☐ Yes	☐ No	Vomiting	☐ Yes	☐ No	Heartburn	☐ Yes	☐ No

Psychiatric:

Excessive Stress	☐ Yes	☐ No	Memory Loss	☐ Yes	☐ No	Nervousness	☐ Yes	☐ No
Behavioral Change	☐ Yes	☐ No	Disorientation	☐ Yes	☐ No	Hallucination	☐ Yes	☐ No
Disturbing Thoughts	☐ Yes	☐ No	Mood Changes	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Psychiatric Disorders	☐ Yes	☐ No						

MEDICATION LIST:
(please include vitamins, fish oil and aspirin)

Name	Dose and Frequency	Name	Dose and Frequency

Social History: Please check if you:

_____ **Smoke (# packs per day and how many years, or used to smoke)**
_____ **Drink Alcohol (or used to)**
_____ **Use Illicit drugs**
_____ **Have/had an addiction problem**

Medical and Surgical History:

Please List	Date

MEDICATION ALLERGIES:

CHECK HERE IF NONE: ____

(please include Eggs and Shellfish)

Please List Name	Reaction

Family History:

Do any of your family members have medical problems? (Please list: High Blood Pressure, Diabetes, Cancer, Addiction, other)

☐Mother: DOB: _____ If deceased what age? _____ Problems: _____

☐Father: DOB: _____ If deceased what age? _____ Problems: _____

☐Sister: DOB: _____ If deceased what age? _____ Problems: _____

☐Brother: DOB: _____ If deceased what age? _____ Problems: _____

Acknowledgement of Patient Bill of Rights

By signing this disclosure you or your legal representative, acknowledge that: (1) you are receiving this notice prior to the date of the procedure and/or visit; (2) you have been informed of your patient rights; (3) you have been informed of the financial interests of the practitioner in this office; (4) you voluntarily desire to have your procedure performed at the facility; (5) you have been informed that part or all of your procedure may be considered "out-of-network", if applicable; (6) you have the right to enter into an advance directive; and (7) you have the right to make informed decisions regarding your care.

Understood and agreed:
Patient/Responsible Party

_____
Print Name

_____
Patient Signature

_____
Date

Witness:

_____
Print Name

_____
Signature

_____
Date

Complaints may be lodged with the following:

N.J. Department of Health and Senior Services
Division of Health Facilities Evaluation and Licensing
P.O. box 367
Trenton, NJ 08625-0367
Complaint Hotline: 1-800-792-9770
http://www.state.nj.us/health/healthfacilities

and/or

Office of the Medicare Beneficiary Ombudsman
http://www.medicare.gov/Ombudsman/activities.asp

Original—Office Chart
Copy: Patient/Responsible party

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Hoboken Medical Center, Hoboken, NJ
Newark Beth Israel Medical Center, Newark, NJ

STATEMENT OF FINANCIAL RESPONSIBILITY

Patient Name: _____ **DOB:** _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment to NJSPI (the "NJSPI") of any insurance benefits otherwise payable to me or on my behalf for the services performed by NJSPI staff, its affiliates and subsidiaries. This Assignment of Benefits is valid for all insurance companies and programs, including Medicare.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize NJSPI, it affiliates and subsidiaries to release medical information related to the procedure(s) as may be requested by third party payers to process payment of my claims.

CHARGES

I understand that the fees for anesthesia services are separate from the Surgery Center's facility fees and my surgeon's fees. I understand that NJSPI ("NJSPI") is only a network provider with Medicare. The payment by your insurance company may be based on your out-of-network benefits and the status of your deductible.

APPEAL, DOBI AND ARBITRATION

I consent to and authorize NJSPI to file any appeal for payment, mediation by DOBI arbitration or legal action by an attorney on my behalf. I waive any conflict of interest that exists, or may exist in the future, between me and NJSPI.

CREDIT POLICY

After your procedure, a claim will be filed with your insurance carrier. You will be notified when an action by your insurance company has been taken. At all times, you are fully responsible for all charges less any payments received by NJSPI from any insurance carrier paid on your behalf. Your insurance contract is between you and the insurance company. It is your responsibility to question your insurance company about delays in payment, amount of payment and/or denial of coverage, as well as any requirements to have a second surgical opinion and pre-certifications If any funds are owed, payment will be expected within 10 days of the receipt of the notice.

If your insurance company issues payment to you, you are responsible to send NJSPI the full payment along with a copy of the Explanation of Benefits that came with your insurance company check. If I receive any payment directly, I agree that I will hold such payments in trust for NJSPI and I also agree to send any such payment to NJSPI within one week after I receive same. In the event that you do not forward your insurance payment in timely manner and we are forced to utilize the services of a collection agency and/or an attorney, you will be responsible for all of the costs of collection *in* addition to the amount originally owed by you.

I HAVE READ AND UNDERSTAND THE TERMS OF THIS FINANCIAL RESPONSIBILITY STATEMENT

Patient's Signature _____ **Date** _____
(Parent/Guardian if minor/dependent)

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NOTICE OF PRIVACY

Please complete the following and check all that apply:

HIPAA DISCLOSURE AND AUTHORIZATION

- ☐ I hereby acknowledge that I have been given opportunity to request materials of the Health Information Portability and Accountability Act (HIPAA)/Notice of Privacy Practice.
- ☐ I have received a copy of New Jersey Spine & Pain Institute's Notice of Privacy Practices.

I give my permission to release information to the following individuals during my visit:

_____ _____

Note: Our office reserves the right to leave messages on your answering machine regarding your appointment and/or billing issues, if our attempts to speak with you personally have failed.

I authorize my physician and/or clinical staff to disclose the following protected health information to:

- ☐ Myself only
- ☐ My spouse, partner, or parent (Specify Name) _____
- ☐ Other (Specify Name)

Information to be disclosed:

- ☐ Lab/ Test Results
- ☐ Prescriptions
- ☐ Referrals
- ☐ Diagnosis

Indicate the phone number to be contacted:

Home phone # _____ Cell # _____

Work phone # _____ Cell # _____

Indicate your choice:
Yes, I give permission for medical information to be left on my answering system.

No, I do not want medical information left in my answering system.

I understand that I have the right to revoke this authorization in writing to the Office Manager at 19 E. 27th Street, Bayonne, NJ 07002
I understand that disclosed information pursuant to this authorization may no longer be protected by the federal HIPAA Privacy Rule of state law.

_____
Please Print Name

_____ _____
Patient Signature (Parent or Legal Guardian) Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but was not able to because:

☐ Individual refused to sign ☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency prevented us ☐ Other (Please specify) _____

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CONSENT FOR CHRONIC OPIOID THERAPY

I, _____ am fully aware that Joseph Ibrahim, M.D., FAAMR and/or any officially designated representative of the New Jersey Spine and Pain Institute, LLC (NJSPI) is prescribing opioid medicine, sometimes called narcotic analgesics as part of my pain therapy. I attest to the following statements:

PLEASE INITIAL ON LINES

_____ 1. I understand that New Jersey Spine and Pain Institute reserves the right to order a drug screen upon initial evaluation and randomly at any time that I am prescribed opioid/narcotic medication and I will comply if such a request is made.

_____ 2. I have never been involved in the sale, diversion and/or transport of controlled substances.

_____ 3. I will obtain all prescriptions for narcotic analgesics from **ONLY** New Jersey Spine and Pain Institute and reveal all other medications that I am taking.

_____ 4. I will only use ONE pharmacy for filling prescription analgesics.

_____ 5. I give my permission to allow New Jersey Spine and Pain Institute staff and physicians to discuss my case with my other physicians and pharmacists.

_____ 6. I agree to take my medications **ONLY AS PRESCRIBED BY** Dr. Joseph Ibrahim and/or associates.

_____ 7. I agree to follow the advice of the physicians/nurse practitioner/physician assistants of the New Jersey Spine and Pain Institute regarding the stopping of controlled substances as they advise.

_____ 8. I am not currently abusing illicit or prescription drugs and I am not undergoing treatment for substance dependence or abuse.

_____ 9. I understand that New Jersey Spine and Pain Institute will make **NO** allowances for lost prescriptions or medications nor will we refill controlled medication in advance of their refill date.

_____10. I understand that prescriptions will not be mailed and must be given to you **IN PERSON** at the time of your appointment.

_____11. **(FEMALES ONLY)** I certify that I am not pregnant if I plan to become pregnant or believe that I have become pregnant while taking pain medication, I will immediately call my obstetric doctor and this office to inform them. I am aware that if I should carry a baby to delivery while taking these medications, the baby will become physically dependent upon opioids. I am aware that the use of opioids is generally not associated with a risk of birth defects. However, birth defects can occur whether the mother is on medicines and there is always the possibility that my child will have birth defects while I am taking an opioid.

_____12. **(MALES ONLY)** I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood level.

_____13. **I understand that New Jersey Spine and Pain Institute reserves the right to dismiss me from care should any violations of the above occur.**

I have read this entire agreement and have had the opportunity to ask questions which have been answered to my satisfaction. I consent to the use of analgesics under the terms outlined in the agreements. I will be given a copy of this policy for my reference, if requested.

Patient Signature: _____ **Date:** ____/____/____ Witness: _____

Patient Name (Printed): _____ Physician/Nurse Practitioner: _____

NEW JERSEY SPINE AND PAIN INSITUTE, LLC

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ASSIGNMENT OF BENEFITS

I irrevocably assign to you my medical provider, all of my rights and benefits under any insurance contracts for payment for services rendered to me by NEW JERSEY SPINE AND PAIN INSTITUTE. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claim by NEW JERSEY SPINE AND PAIN INSTITUTE to be released to NEW JERSEY SPINE AND PAIN INSTITUTE. I irrevocably authorize NEW JERSEY SPINE AND PAIN INSTITUTE to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to NEW JERSEY SPINE AND PAIN INSTITUTE. I irrevocably authorize NEW JERSEY SPINE AND PAIN INSTITUTE to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

I irrevocably authorize NEW JERSEY SPINE AND PAIN INSTITUTE to obtain counsel and enter legal or other action on my behalf and/or in my name, including the arbitration/dispute resolution process, to collect such sums due it should sums not be paid within the legally prescribed time frame. In the event that NEW JERSEY SPINE AND PAIN INSTITUTE elect to bring a lawsuit or petition for arbitration/dispute resolution against the insurance carrier, I irrevocably assign my rights title, and interest under the medical expense benefits and/or pip section of any insurance policy under which I am entitled to proceed for benefits. This assignment shall allow an attorney of NEW JERSEY SPINE AND PAIN INSTITUTE's choosing to bring suit or submit to arbitration/dispute resolution their claim for any unpaid bills for services rendered for injuries that I sustained in this or any accident.

In the event that this assignment is held invalid for any reason, I hereby authorize NEW JERSEY SPINE AND PAIN INSTITUTE to appoint any attorney of its choice to represent me directly against an insurer from which I may collect pip benefits and to bring a claim in a forum of its choice. This appointment is intended on enabling the attorney to collect the bills of NEW JERSEY SPINE AND PAIN INSTITUTE.

The undersigned patient does hereby agree and acknowledge that he/she may receive benefit checks directly from the insurance carrier for services rendered by the provider. The undersigned patient hereby agrees to hold such payment in trust for NEW JERSEY SPINE AND PAIN INSTITUTE and to send such payment to NEW JERSEY SPINE AND PAIN INSTITUTE within one week after receipt.

A photocopy of this assignment shall be valid as the original. This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

I authorize you and/or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc. And I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, x-ray reports, narrative reports, and any other report or information regarding my physical condition.

_____ _____

PATIENT SIGNATURE DATE

New Jersey SPINE & PAIN INSTITUTE

Joseph Ibrahim, MD, FAAPMR

Dear Valued Patient,

We would like to inform you that our office, NEW JERSEY SPINE AND PAIN INSTITUTE, LLC is **"Out-of-Network"** since 2013, for major insurance plans. As well, the office of NEW JERSEY SPINE AND PAIN INSTITUTE, LLC., is a **"Non-Billing Medicaid Provide"** and **he does not participate** with MEDICAID or any Medicaid Products. Furthermore, Dr. Joseph Ibrahim cannot bill Medicaid for any services provided by him and his office. You will be financially responsible for any service provided that is not covered by your insurance.

Our practice is open to patients with all types of plans that allow choice of provider (PPOs), in addition to patients who choose to receive care outside of their plan (HMOs). We certainly hope to continue to provide care for all our patients.

We will continue to file your insurance claims and accept payments directly from carriers (as out-of-network providers). The deductible and coinsurance are your responsibilities.

We have revised and printed out our policies and procedures for cases of financial hardship.
There are several ways in which we can work with patients in these circumstances. Please contact our Billing Department (201) 436-0033 to discuss specifics.

We support the goals of health plans and employers seeking to reduce unnecessary costs and utilization and will continue to do so. We believe that our practice, patients, area employers, and even health plans will benefit from the steps that we are taking toward a more efficient and straightforward process in handling insurance issues.

We recognize that individual benefit plans and circumstances differ and that questions will remain. We ask that you direct your questions to our Billing Department who will happy to assist you.

Thank you for continuing to entrust your care to New Jersey Spine and Pain institute LLC.

Sincerely,

NEW JERSEY SPINE AND PAIN INSTITUTE, LLC.

Signature of Patient	Printed Name	Date

19 E 27th Street
Bayonne, NJ 07002
P) 201.436.0033
F) 201.436.0079

59 Seeley Ave.
Kearny, NJ 07032
P) 551.580.7815
F) 551.580.7826

2520 John F. Kennedy Blvd.
Jersey City, NJ 07304
P) 201.984.9055
F) 201.963.6165

NEW JERSEY SPINE AND PAIN INSITUTE, LLC

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Financial Policy

- We are committed to providing you with the best possible care.
- We expect that you have an understanding of your responsibilities under your insurance contract in respect to referral and pre-authorization requirements, and your deductible, co-pay, and coverage limits.
- Payment is due, in full, at time of service, unless you have made payment arrangements in advance with our business office.
- If you have insurance coverage with one of the plans we participate with, we will bill your insurance company along the guidelines of our contract. However, we require that **ALL COPAYS OR DEDUCTIBLES** be paid at the time of service.
- If you have an insurance with which we do not participate, we ask that payment be made at the time services are rendered and your insurance company will reimburse to you directly any amount due.
- Returned checks will be subject to an additional $25.00 service fee.
- We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Please realize however that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
- While filing of insurance claims is a courtesy we extend to our patients; all charges are the responsibility of the patient from the date the services are rendered.
- You will be required to show a copy of your insurance card at the time of service. If you do not have your insurance information or we are unable to verify your coverage, **you will be required to pay for the services rendered to you that day**. If your insurance coverage terminates or changes, you are responsible for notifying us of this change immediately so that we can assist you in receiving your maximum reimbursement.
- Any account balance outstanding in excess of 30 days will be subject to a service charge of 1.5% monthly.

Missed Appointments

- Please help us serve you better by keeping scheduled appointments.
- **Unless cancelled at least 48 hours in advance, our policy is to charge a <u>NO SHOW FEE</u>** of **$50.00** for missed office appointments and **$75.00** for missed procedures appointments.

I HAVE READ the Financial Policy. I **UNDERSTAND** and **AGREE** to this Financial Policy. I **GUARANTEE** payment of all charges incurred for the account of the below patient. I hereby assign benefits to New Jersey Spine and Pain for all claims submitted to my insurance on my behalf. I further agree to pay any attorney's fee, court cost, and related collection fees incurred.

_____ X_____ _____

Patient Name Signature Date

Thank you for your understanding and cooperation. We look forward to seeing you in our office soon.

Joseph Ibrahim, M.D.
19 East 27th
Bayonne, NJ 07002
Phone: (201) 436-0033 Fax: (201) 436-0079

New Jersey

SPINE & PAIN

INSTITUTE

Joseph Ibrahim, MD, FAAPMR

OPIOID RISK TOOL

Patient Name _____

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1

TOTAL

Total Score Risk Category Low Risk 0 – 3 Moderate Risk 4 – 7 High Risk $\geq$ 8

_____ _____

Patient Signature (Parent or Legal Guardian) Reviewed by

_____ _____

Date Date