

Chronic Pain Management Program
Evaluation, Treatment and Partnership with the Pain Team
Consent Form

I wish to participate in the Kaiser Permanente Chronic Pain Management Program.

I understand the following:

1. I will work with my provider(s) and the Chronic Pain Management Team, which consists of a pain physician, psychologist, clinical pharmacist, physical therapist, and RN care manager regarding the management of my pain.
2. One of the key functions of the pain program is not to cure my chronic pain, but to help me learn the best methods of managing my chronic pain.
3. If it is recommended that I attend classes (group appointments) which will teach me self-management skills, I will:
 - a. Attend all group sessions and be on time
 - b. Actively participate in all group activities
 - c. Spend time each day doing homework assignments
 - d. Keep a pain diary, if indicated, and record medications that I take for my pain
 - e. Practice deep breathing and relaxation techniques
 - f. Practice exercise and movement as recommended by pain program physical therapist (undergarments must be worn for all visits with the physical therapist)
4. I understand that participation in the chronic pain management program will be reviewed by the pain team if I fail to keep a scheduled appointment.
5. I understand that the partnership means that I will work with the pain team to achieve the goal of managing the pain by the methods that the pain team recommends as appropriate.

Name: (print) _____

Signature: _____

(means that I have been informed)

Medical Record Number: _____

Date: _____