PROFESSIONAL LIABILITY ASSOCIATION
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:

   _____

   _____

   _____

9300 Shelbyville Rd., Suite 204● Louisville, KY 40222 v (866) 749-2273 / (502) 895-6404 f (866) 797-2273 / (502) 895-6406

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	_____
Adjuvant analgesics		_____

Others (please list): _____

_____

15. What ancillary therapies are used in your pain management practice? (Circle 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. Please specify any procedures not listed above for which you wish to be insured:

_____

_____

_____

_____ _____
Physician's Signature Date

It is important that you keep us informed of any changes in your practice so that we can provide you with adequate coverage.

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