

(Attach Label here or Complete Details)

NAME: _____ NHI: _____

GENDER: ____ DOB: _____ AGE: ____ WARD: _____

Intraspinal analgesia pre-operative assessment

Admission date: _____ Referral date: _____

Date of procedure: _____ Intrathecal / Epidural (delete one)

Diagnosis: _____

Indications for Intraspinal therapy (tick one or more):

☐ Inadequate pain relief

☐ Sedation

☐ Confusion

☐ Other: _____

Pain Score: (0-5) 0 = no pain 1 = mild discomfort 2 = moderate discomfort 3 = painful
4 = severe pain 5 = excruciating

At time of referral: _____ Average in last 7 days: _____

Clinical evidence of infection in last 7 days? _____

Other strong opioids used in last month? _____

Pain sites and pain description:

1.

2.

3.

Mobility (tick one only): ☐ Fully ambulant ☐ Frame ☐ Bed / Chair ☐ Bedbound

IDUC / Urodome: ☐ Yes ☐ No Ileostomy / Colostomy: ☐ Yes ☐ No

Drug	Route	24 hour dose	Name & designation	Signature
Morphine				
Morphine				
Other opioid: _____				
NSAID				
Paracetamol				
Steroid				
TCA				
Anticonvulsant				
MSA				
Benzodiazepine				
Other: _____				

Name

Designation

Signature

Date