Dr/Practice Name

Address/Phone/Info

Chronic Pain Disease & Palliative Care Certification Form

Patient Information

Patient Name:		Date of Birth:	
Address:		Telephone #:	
City, STATE, Zip:		Cellphone #:	

The patient has the following primary diagnosis without an available cure: (Physician ONLY)

1.	
2.	
3.	
4.	

The Patient has tried unsuccessfully (items below) for relief for this condition.

(Additional Responses can be written on a separate sheet of paper)

1.	
2.	
3.	
4.	

Certifying Physician Use Only

	Palliative Care Criteria
▣ YES☐ NO	The underlying disease has no cure
▣ YES☐ NO	There is a likelihood the disease will shorten lifespan
▣ YES☐ NO	Symptomatic treatment has a high probability of improving the quality of life

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Palliative Care Treatment will consist of, but not limited to the following:

(Additional Responses can be written on a separate sheet of paper)

	Medications / Other Treatment's
1.	
2.	
3.	
4.	

Optimal Therapeutic MME (Morphine Milligram Equivalent) Range for effective control of pain for this Certificate holder:

☐ **50-100** ☐ **100 to 200** ☐ **200 to 300** ☐ **300 or more _____**

Diagnosis / Symptom Codes

Symptom Codes	**Symptom Code Descriptions:** **Examples:** Chronic Pain (G89.29), Cough (R05), Intractable Vomiting (G43.A1), Shortness of Breath (R06.02), Diarrhea (R19.7).

_____
Patient Initial

It is my opinion that this patient is not an opiate misuser, abuser, or diverter. To the best of my knowledge this patient is not involved in any illegal or illicit drug activity, nor has a known addiction disease.

The palliative care protocol is not to be modified without notification to the certifying physician unless superseded by state or federal law. Prescription(s) that cannot be honored or filled immediately are not considered in the best interest of this Certified Palliative Care Patient and need be discussed with the certifying physician. There will be no dosage or agent changes on any legally prescribed medications for this special exempt category of disease defined by CDC and by applicable state laws without consultation with the certifying physician. ***Before denying or refusing to fill a prescription written from this prescriber, a call from the Managing Pharmacist is Requested, and deemed necessary for proper care.***

Patient Name: _____

Patient DOB: _____

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Authority

1.	**Federal Palliative care, pain medicine restriction exemption:** CDC Guideline March 15, 2016, page 1, line 1, *"As part of the U.S. government's urgent response to the epidemic of overdose deaths, the Centers for Disease Control and Prevention (CDC) today is issuing new recommendations for prescribing opioid medications for chronic pain, **excluding** cancer, **palliative**, and end-of-life care"*
2.	**Palliative care exemption: for state of : _____ Detail(s) of the Palliative Care Law & Exemptions Below**
3.	

I, _____ have performed a comprehensive and detailed examination for _____ (patient) on this date:

I have determined that this person has satisfied the criteria for Palliative Care Status.

I, hereby, certify and approve this long term plan of palliative care, which will be recertified in one year from the below date. I will be responsible for all palliative treatment during this certification year, with option(s) for annual renewals. Patients will be monitored via phone, and in person visits.

Signed under pain and penalty of perjury.

Signature: _____ Date:

Licensed Medical Practitioner: _____
License: _____ State:____
DEA Number: _____

To the patient: By signing below, and initialing above you hereby agree to all terms and conditions set forth under this agreement.
Signature of Patient: _____ Date: ___ / ___ / _____
Patient Name Printed: _____

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Patient Name: _____
Patient DOB: _____