Oklahoma Joint
Reconstruction Institute
Paul B. Jacob, DO

9800 Broadway Extension, Oklahoma City, OK 73114 P:405.424.5426

How did you hear about our practice? Use dropdown or type answer **Who Referred you?:**

PATIENT INFORMATION

(Please fill in all blanks)

Last:	**First:**	**MI:**	**Sex:**	**DOB:**	**Age**:

Social Security #: **Marital Status:** ◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Separated

Address: **Employment:** ◯ Employed ◯ Full-time student ◯ Part-time student ◯ Retired

City:	**State:**	**Zip Code:**	**Email:**

Home Phone:	**Work Phone:**	**Cell Phone:**	**Language:**

Ethnicity: ◯ Hispanic ◯ Non-Hispanic ◯ Declined **Race:** ◯ White ◯ Asian ◯ Black ◯ Pacific ◯ Native American ◯ Multiple ◯ Other

INSURANCE INFORMATION – We will need a copy of your insurance card in order to file a claim.

Name of Primary Insurance Company:

Policyholder Name:	**Relationship to Patient:**
Policyholder DOB:	**Policyholder SSN:**

Policyholder Employer:

Secondary Insurance (if applicable):

Policyholder Name:	**Relationship to Patient:**
Policyholder DOB:	**Policyholder SSN:**

Policyholder Employer:

EMPLOYMENT INFORMATION

Patient's Employer:	**Phone Number:**
Insured Employer:	**Phone Number:**

If the patient is a minor, please list both parent names and employers

Mother:	**Employer:**	**Phone Number:**
Father:	**Employer:**	**Phone Number:**

NEXT-OF-KIN INFORMATION

Nearest relative (or friend, not spouse), not living with you:

Home Phone:	**Relationship to Patient:**

THIRD PARTY BILLING (choose one)

Is your injury work related?	◯ YES ◯ NO
Is this injury due to an accident?	◯ YES ◉ NO
If your injury is MVA related have you obtained an accident report?	◉ YES ◯ NO

I hereby authorize my insurance to be paid directly to the facility and the physician. I acknowledge that I am financially responsible for non-covered services. I also authorize the physician to release my information in the processing of any insurance claims. I acknowledge & agree that I have received a copy of the TPG Privacy Notice.

Signature:	**Date:**

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AUTHORIZATION FOR TREATMENT

I hereby authorize the physician(s) in charge of the care of the patient of Oklahoma Joint Replacement Institute to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the physician(s) of Oklahoma Joint Reconstruction Institute to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of Oklahoma Joint Reconstruction Institute charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the physician's treatment or charge including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers' compensation carriers, welfare funds, the Social Security Administration or its intermediaries or carriers. I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE DISEASE WHICH MAY INCLUDE BUT IS NOT LIMITED TO DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning identity, and release Oklahoma Joint Reconstruction Institute, its agents and its employees from liability in connection with the release of the information contained therein.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit at Oklahoma Joint Reconstruction Institute. I understand I am financially responsible for charges not covered by this assignment.

You agree that, to the fullest extent permitted by law, we may remit all or a portion of any credit balances or other amounts due to you from us to any of our affiliates to whom you have any balance owing fees, items or services. We will advise you of any payments we make on your behalf to our affiliates.

WAIVER OF RESPONSIBILITY OF VALUABLES

I hereby release Oklahoma Joint Reconstruction Institute from any claim for responsibility or damages in the event of loss of my property, including money and jewelry.

I understand a photocopy of this document is as valid as the original.

_____ _____
Patient Signature Date

OR

_____
(Nearest relative or responsible party)

_____ _____
(Relationship to patient) Policyholder's Signature

NOTICE TO PATIENTS: Information in your medical record that you have/may have a communicable or venereal disease is made confidential by law and cannot be released without your permission, except in limited circumstances, including release of persons who have had risk exposures, release pursuant to an order of the court of the Dept. of Health, release among healthcare providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court, or the Dept. of Health, or by law.

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OKLAHOMA JOINT RECONSTRUCTION INSTITUTE

Authorization to Release Information via Phone/Family/Friends

Patient Name: _____DOB:_____

I hereby authorize confidential communications from the physicians or staff of OJRI regarding my health, care, treatments, appointments, prescriptions, etc…to be received at any of the numbers given below. I authorize the staff to leave messages on the voicemail or with the individual who answers the phone at any of the below numbers:

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Other:** _____

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plans, medications and account information. These individuals may also pick up prescriptions and/or samples that I have requested:

Name: _____ **Relation:**_____

Name: _____ **Relation:**_____

Name: _____ **Relation:**_____

Name: _____ **Relation:**_____

I understand that this authorization will remain in effect until I revoke the authorization in writing.

☐ **I AGREE** to the terms as stated above

☐ **I DECLINE,** please **DO NOT** leave any messages

_____ _____
Patient Signature Date

OJRI STAFF ONLY	Documented by: Initials:_____	Date:_____

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Paul B. Jacob, DO

9800 Broadway Extension, Oklahoma City, OK 73114 P:405.424.5426

DISCLOSURE OF PHYSICIAN OWNERSHIP NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Dr. Paul Jacob has an ownership interest in Community Hospital and Northwest Surgical Hospital.
2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.
3. You have the right to choose the provider of your healthcare services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visits our website(s), communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

_____ _____

Signature of the Patient Date

_____

Printed name of the Patient

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Reconstruction Institute
Paul B. Jacob, DO

9800 Broadway Extension, Oklahoma City, OK 73114 P:405.424.5426
Oklahoma Joint Reconstruction Institute
A DIVISION OF THE PHYSICIANS' GROUP

FINANCIAL POLICY

Thank you for choosing Oklahoma Joint Reconstruction Institute (OJRI) are you healthcare provider. At OJRI, we are dedicated to providing the highest quality, most cost effective care.

In addition to accepting traditional insurance plans and Medicare we are contracted with numbers Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO). Because each plan is different, and constantly updating providers' participation status, please check with your particular plan to make sure we are currently participating in your network. We ask that you assist us in maximizing your insurance coverage by cooperating fully in all referral, prior authorization and pre-certification processes. **Please be aware that all insurance carriers do not consider some services rendered a covered benefit. It is important that you are aware of your insurance policy provisions of coverage.**

Accurate, up-to-date information is the patient's responsibility; please notify our office of any changes in your insurance or personal billing information. Please bring your current insurance card, or any other information that is required by your insurance company to each appointment. By maintaining updated information this ensures that your medical claims are filed correctly and prevents any unnecessary delays in processing your claim.

Payment for all co-insurance, deductible and non-covered services are due at the time of service unless special payment arrangements have been made. Payments can be made by cash, check, money order, Visa, Discover, American Express or MasterCard. We do have a payment plan for patients who have financial concerns. Please notify our office at 405.424.5426 to make financial arrangements. Please be aware that charge for physical therapy, durable medical equipment, laboratory testing, anesthesia, hospital, ambulatory surgery facilities and some radiology services may be billed separately.

If your injury was due to a motor vehicle accident (MVA) you will be setup on a self-pay account for any charges incurred up to $500. If charges exceed $500, a claim will be filed with the third party insurance carrier. In order to file this claim, complete billing information will be requested from the patient. A lien may be filed with the third party in order to ensure payment to the physician. **Please note that not all OJRI Physicians will accept third party/MVA patients.**

There is a $35 charge any FMLA, disability or accidental form completed. This charge is applicable per form completed any is payable prior to completion.

If you require surgery or other invasive procedures and are scheduled at Community Hospital or Northwest Surgical Hospital, please be advised that your physician may have ownership in those facilities. If you wish, you may request another facility.

Again, than you for allowing Oklahoma Joint Reconstruction Institute to participate in your care.

Sincerely,

Team OJRI

My signature below acknowledges receipt of this Financial Policy:

Signed_____ Date_____
(signature of person financially responsible for payment)

Relationship if other than patient_____

Oklahoma Joint Reconstruction Institute

Paul B. Jacob, DO

Dear Patient,
I would like to be the first to welcome you to ***Oklahoma Joint Reconstruction Institute***. We know you have many choices when it comes to your orthopedic needs and we thank you for trusting us with your care. We also want to thank you for taking your valuable time to fill out this packet of information as it will help us to better understand your condition.

Your first appointment will take approximately 30-45 minutes, and I will do my best to run as close as possible to your allotted appointment time. I do take care of urgent / emergent patients and I ask for your understanding and patience as from time to time your appointment may get rescheduled or I may be running late. I agree to extend the same courtesy to my patients' as I understand that unforeseen events may delay your arrival. I will do my best to accommodate late patients as my schedule permits. The attached packet will give you some important details on my practice. Please don't hesitate to contact me personally at ***drjacob@drpauljacob.com*** or my scheduler at **(405) 424-5426** with questions at any time during your care.

I am a Board Certified and Fellowship Trained Orthopedic Surgeon specializing in advance hip and knee replacement and adult reconstruction. I was fortunate to have to opportunity to complete my training at the world-renowned Cleveland Clinic in Cleveland, Ohio. My experience working with some of the world's leading experts in the field of adult reconstruction has allowed me to bring the most advanced techniques in minimally invasive surgery to the state of Oklahoma. This includes robotically assisted and minimally invasive hip and knee replacement utilizing the latest in rapid recovery protocols. My practice is solely focused on adult reconstruction of the lower extremity. I am committed to providing the most advanced techniques available for the residents of the state of Oklahoma and surrounding states.
I am passionate about achieving excellent results for my patients. A caring, professional approach to patient care combined with advanced surgical techniques is paramount. I also believe that monitoring of surgical results is critical. I am proud to say that our practice actively participates in the American Joint Replacement Registry.

WHAT TO BRING TO YOUR APPOINTMENT

- Driver's License or a valid ID
- Insurance information (card)
- Medical records from previous orthopedic surgeons
- Disc of previous imaging (X-rays, MRIs, CT scans etc.)
- List of medications (if any)
- Hospital medical records from previous surgeries

We realize that you will receive a great deal of information regarding your diagnosis and its associated treatment in a very short period of time. The amount and pace of information can be overwhelming. My website ***www.drpauljacob.com*** contains further information about my practice, research and experience. It also contains useful educational material on your diagnosis, surgical procedure and rehabilitation. If you are not provided with all the answers to your questions from these resources, please do not hesitate to contact us at any time for further assistance.
The prospect of undergoing a major surgery can sometimes be a stressful on you and your loved ones. We have designed a full program to inform you of your options, educate you on the process and minimize any stress / inconvenience that you may experience.
No matter your level of activity; whether you want to return to high level sport or be free of pain and enjoy everyday life, I am dedicated to helping you achieve your goals and live life to the fullest. I hope to be of assistance and look forward to meeting you soon.

Sincerely,

Paul B. Jacob D.O.
Oklahoma Joint Reconstruction Institute
Board Certified and Fellowship Trained Orthopedic Surgeon
Specializing in Advanced Reconstruction of the Hip and Knee
Email: drjacob@drpauljacob.com
Office: (405) 424-5426
Fax: (405) 424-5431
Website: www.drpauljacob.com

General Patient Information

Name:_____ Age:_____ Date Of Birth:_____ Height:_____ Weight:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Preferred contact method: ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Other:_____

Emergency Contact Name:_____ Phone #:_____

Pharmacy Name: _____ Phone#_____

Reason for the Visit?

- ☐ Hip Pain ☐ Left ☐ Right ☐ Bilateral
- ☐ Knee Pain ☐ Left ☐ Right ☐ Bilateral
- ☐ This is a second opinion
- ☐ I have a problem with my existing hip / knee replacement
- ☐ Other:_____
- ☐ When did symptoms begin?_____

Please let us know if you see any of the following physicians:

Primary care physician:_____ Cardiologist (heart doctor):_____

Rheumatologist (arthritis doctor):_____ Pulmonologist (lung doctor):_____

Pain Management:_____ Nephrologist (kidney doctor):_____

Other:_____

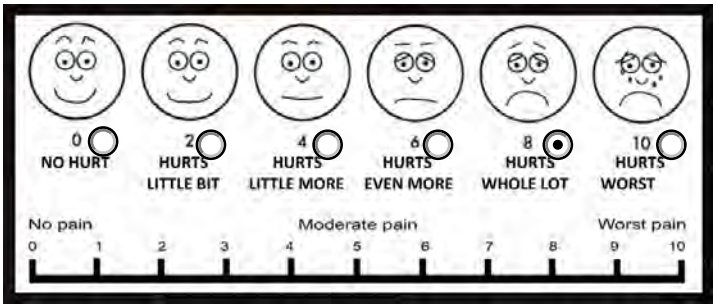
In your words please describe why you are seeing Dr. Jacob:_____

_____

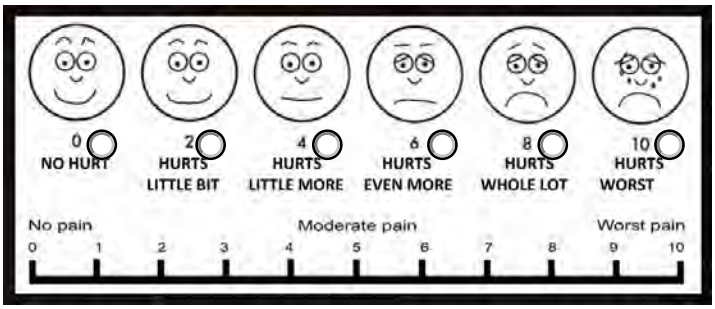
_____

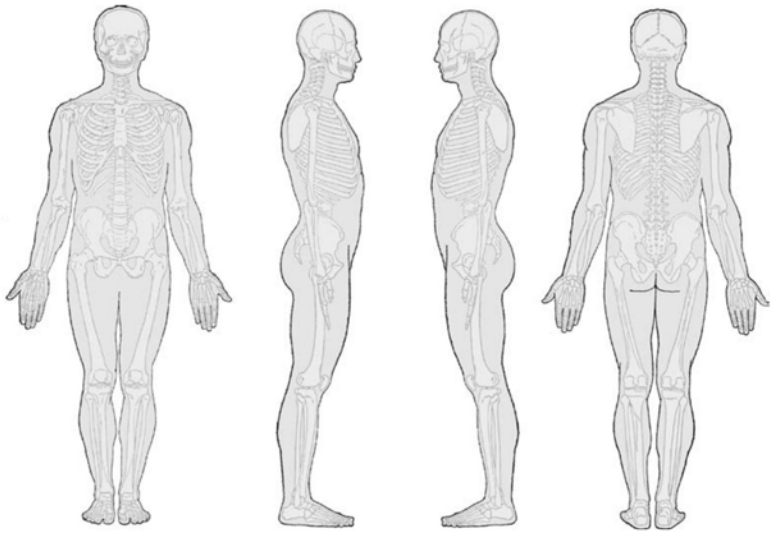
_____

Circle the number below that best corresponds to your pain at its ***BEST***



Circle the number below that best corresponds to your pain at its ***WORST***





Mark with an "X" where you are experiencing your pain

Please check all the boxes that describe your symptoms:

- ☐ Aching
- ☐ Throbbing
- ☐ Burning
- ☐ Numbness
- ☐ Tingling
- ☐ Heaviness
- ☐ Locking
- ☐ Grinding
- ☐ Stiffness
- ☐ Sharp
- ☐ Stabbing
- ☐ Electric shock
- ☐ Ants crawling
- ☐ Pins / Needles

Past Treatments

Insurances often will not approve major surgeries like hip or knee replacements until the patient has made attempts at conservative treatment for a minimum of 3 months. Please indicate all conservative treatments you have attempted below:

☐ I CAN NOT TAKE ANTI-INFLAMMATORY MEDICATIONS (REASON):_____

WEIGHT LOSS	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
ACTIVITY MODICATION	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
OVER THE COUNTER MEDS	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
PRESCRIPTION NSAID'S	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
PRESCRIPTION PAIN MEDS	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
TOPICAL MEDS	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
ALTERNATIVE MEDS	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
PHYSICAL THERAPY	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
AQUATIC THERAPY	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
CHIROPRACTIC	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
ACUPUNCTURE	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
HOME EXERCISE	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
STEROID INJECTION: #_____	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
GEL INJECTIONS: #_____	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
STEM CELL INJ. #_____	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
PRP INJECTIONS #_____	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
BRACING	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
WALKER / CANE / CRUTCH	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
REST / ICE / ELEVATION	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
NERVE BLOCKS	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
ARTHROSCOPIC SURGERY	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
OSTEOTOMIES	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
CARTILAGE TRANSPLANT	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
MICROFRACTURE	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks
ORTHOTICS / TAPING	☐ YES ☐ NO	I have tried this treatment over the following timeframe	☐ **Less** than 12 weeks	☐ **Greater** than 12 weeks

Please describe any other treatments that you have attempted that are not listed above:_____

_____

_____

_____

_____

Review of Systems

Please check the box next to any of the symptoms you are experiencing currently.'

- ☐ I DO NOT HAVE ANY OF THE FOLLOWING SYMPTOMS
- ☐ I am currently pregnant

General:
- ☐ Chills
- ☐ Excessive Weight Gain
- ☐ Excessive Weight Loss
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Difficulty Sleeping

Cardiovascular:
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Palpitations
- ☐ Irregular Heartbeat
- ☐ Leg Swelling
- ☐ Pitting Edema
- ☐ Heart Murmur
- ☐ Fainting

Skin:
- ☐ Discoloration
- ☐ Easy Bruising
- ☐ Hives
- ☐ Rashes
- ☐ Open wounds
- ☐ Reaction to Metal
- ☐ Trouble Healing Wounds
- ☐ Have a wound care doctor

Gastrourinary:
- ☐ Urinary Frequency
- ☐ Urinary Retention
- ☐ Bowel Incontinence
- ☐ Bladder Incontinence
- ☐ Constipation

Hematology:
- ☐ Excessive Bruising
- ☐ Excessive Bleeding
- ☐ Blood Transfusions
- ☐ Anemia

Gastrointestinal:
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Loose stool
- ☐ Poor Appetite
- ☐ Poor Nutrition

Eyes / Ears / Nose / Throat:
- ☐ Vertigo / dizziness
- ☐ Hearing Loss
- ☐ Nose Bleeds
- ☐ Visual Changes
- ☐ Ringing in Ears

Endocrine:
- ☐ Excessive Thirst
- ☐ Heat Intolerance
- ☐ Cold Intolerance

Respiratory:
- ☐ Cough
- ☐ Wheezing
- ☐ Coughing Blood
- ☐ Require oxygen at home
- ☐ History of pneumonia
- ☐ Sleep apnea
- ☐ Use a CPAP

Shortness of breath when:
- ☐ Walking 2 blocks
- ☐ 1 flight of steps
- ☐ When I lay down

Psychiatric:
- ☐ Anxiety / Worrying
- ☐ Depression
- ☐ Excessive Crying
- ☐ Trouble Focusing
- ☐ Memory Loss
- ☐ Mood Swings
- ☐ Excessive Fear

Neurologic:
- ☐ Weakness
- ☐ Tremors
- ☐ Numbness
- ☐ Tingling
- ☐ Burning Sensation
- ☐ Seizures
- ☐ Memory Loss
- ☐ Headaches
- ☐ Paralysis
- ☐ Foot Drop
- ☐ Loss of Consciousness
- ☐ Headaches
- ☐ Slurred Speech

Musculoskeletal:
- ☐ Pain Going Up Stairs
- ☐ Pain Going Downstairs
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Muscle Atrophy
- ☐ Limping
- ☐ Joint Stiffness
- ☐ Leg Length Difference
- ☐ Use of Walker / Cane
- ☐ Trouble Getting Dressed
- ☐ Locking of Joints
- ☐ Popping of Joints
- ☐ Feeling of Instability
- ☐ Joint Swelling
- ☐ Muscle Cramps

Allergic / Immunologic:
- ☐ Hives
- ☐ Persistent Infections
- ☐ HIV Exposure
- ☐ Hepatitis Exposure
- ☐ Rash from Jewelry
- ☐ Rash from Meta

Past Medical History

- ☐ *I don't have any past medical history*

- ☐ Depression
- ☐ Anxiety
- ☐ Cancer
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Heart Burn / Reflux
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Gout
- ☐ Osteoporosis
- ☐ Thyroid Disease
- ☐ HIV

- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hepatitis (other)
- ☐ Hiatal Hernia
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Psoriatic Arthritis
- ☐ Autoimmune Arthritis
- ☐ Fibromyalgia
- ☐ Alcohol Abuse/Addiction
- ☐ History of MRSA
- ☐ Anemia
- ☐ Deep Vein Thrombosis

- ☐ Pulmonary Embolism
- ☐ Bleeding Disorder
- ☐ Factor V Leiden
- ☐ Factor Deficiency
- ☐ Phlebitis
- ☐ History of Seizures
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Obstructive Sleep Apnea
- ☐ MRSA Infection
- ☐ Gastric Ulcers
- ☐ GI Bleeding
- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ Irritable bowel syndrome

Family History

☐ *I don't know my family history*

☐ Heart Attack	☐ High Blood Pressure	☐ Liver Disease
☐ Stroke	☐ Arthritis	☐ Arthritis
☐ TIA (Mini Stroke)	☐ Bleeding Problems	☐ Osteoporosis
☐ Cancer	☐ Blood Clots	☐ Rheumatoid Arthritis
☐ Breathing Problems	☐ Phlebitis	☐ Thyroid Disease
☐ Diabetes	☐ Pulmonary Embolism	☐ Autoimmune Disease

Please use the space below to provide any information you feel we should know about your past or current medical history:_____

_____

_____

_____

_____

_____

Past Surgical History

Please list all of the SURGERIES you have had

Surgery	*Hospital*	*Physician*	*Complications?*	*Year*

Please use the space below to provide any information you feel we should know about your past surgical history:_____

_____

_____

_____

Have you been hospitalized in the past 5 years? ☐ YES ☐ NO

If yes please describe:_____

_____

_____

_____

_____

_____

Social History

Tobacco Use:

- ☐ I Have Never Been a Smoker
- ☐ I Quit Smoking _____(*Days / Months / Years)* Ago
- ☐ I Smoked for _____ Years
- ☐ I Am a Current Cigarette Smoker
- ☐ I Have Smoked for _____ Years
- ☐ I Smoke _____ Packs Per Day
- ☐ I Use Smokeless Tobacco
- ☐ I Use Other Tobacco Products:_____
- ☐ I am interested in quitting

Alcohol Use:

- ☐ I Drink Alcohol Daily
- ☐ I Drink Socially
- ☐ I Don't Consume Alcohol

Drug Use:

- ☐ I Do Not Use Illegal Drugs
- ☐ I Use Recreational Drugs:_____

Exercise:

- ☐ I Do Not Exercise
- ☐ I Exercise Weekly
- ☐ Type of Exercise:_____

Occupation:

- ☐ I Am Currently Working as a(n):_____
- ☐ This was a workplace Injury
- ☐ Employer:_____
- ☐ I Am Currently Unemployed
- ☐ I am Retired from:_____

Lives with (check all that apply):

- ☐ Alone
- ☐ Spouse
- ☐ Children
- ☐ Parent(s)
- ☐ Grandparents
- ☐ Friend / Roommates

Do you have any stairs that you will need to navigate at home? ☐ YES ☐ NO If yes, how many stairs are there in the home:_____

Have you had one of the following heart tests:

(place a ✓)	I have had the following	Year	Location of testing
☐ Yes ☐ No	EKG		
☐ Yes ☐ No	Stress Test		
☐ Yes ☐ No	Echocardiogram (ultrasound of heart)		
☐ Yes ☐ No	Stent Placement?		
☐ Yes ☐ No	Cardiac surgery, please specify:		
☐ Yes ☐ No	Other cardiac procedure:		
☐ Yes ☐ No	Pacemaker/AICD		

if you marked yes to having a Pacemaker or AICD please provide the following info

Date pacemaker was last checked:_____ Model number or type of pacemaker:_____

This model is MRI safe: ☐ Yes ☐ No ☐ I am not sure

☐ I have my pacemaker card and can provide a copy

Please use the space below to provide any information you feel we should know about your cardiac history:_____

_____

_____

CURRENT MEDICATIONS

I am on the following ***PAIN MEDICATIONS***

☐ I am not currently taking any opioid based (narcotic) pain medications

1. Drug Name: _____ Dose: _____ How Often: _____
2. Drug Name: _____ Dose: _____ How Often: _____

Daily Medications (Please include over the counter medication and food supplements).

Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
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Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____

Are you on any Rheumatoid Arthritis or autoimmune disease medications? ☐ YES ☐ NO

- ☐ Methotrexate
- ☐ Sulfasalazine
- ☐ Hydroxychloroquine (Plaquenil)
- ☐ Leflunomide (Arava)
- ☐ Adalimumab (Humira)
- ☐ Etanercept (Enbrel)
- ☐ Golimumab (Symponi)
- ☐ Infliximab (Remicade)
- ☐ Abatacept (Orencia)
- ☐ Certolizumab (Cimzia)
- ☐ Rituximab (Rituxan)
- ☐ Tocilizumab (Actemra)
- ☐ Anakina (Kineret)
- ☐ Secukinumab (Cosentyx)
- ☐ Ustekinumab (Stelara)
- ☐ Belimumab (Benlysta)
- ☐ Tofacitinib (Xeljanz)
- ☐ Mycophenolate Mofetil
- ☐ Azathioprine
- ☐ Cyclosporine
- ☐ Tacrolimus

OTHER:_____

Allergies

(***please describe the reaction on the line provided***)

☐ NO KNOWN DRUG ALLERGIES
☐ I Have an allergy to ***LATEX***
☐ I Have an allergy to **TOPICAL IODINE (BETADINE)**
☐ I Have an allergy to **IV IODINE**

Drug Allergy	Reaction

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY:

ARE YOU CURRENTLY TAKING ANY *HORMONES?* (*ANYTHING* CONTAINING *ESTROGEN OR TESTOSTERONE*)	☐ YES	☐ NO
HAVE *YOU* EVER HAD A BLOOD CLOT ALSO CALLED A DEEP VEIN THROMBOSIS (DVT) IN YOUR LEGS?	☐ YES	☐ NO
HAVE *YOU* EVER HAD A BLOOD CLOT IN YOUR LUNGS OR A PULMONARY EMBOLISM (PE) IN YOUR LUNGS?	☐ YES	☐ NO
HAVE *YOU* EVER HAD PHLEBITIS (SUPERFICIAL BLOOD CLOT)?	☐ YES	☐ NO
HAS AN *IMMEDIATE FAMILY MEMBER* EVER HAD A DVT?	☐ YES	☐ NO
HAS AN *IMMEDIATE FAMILY MEMBER* EVER HAD A PE?	☐ YES	☐ NO
HAS AN *IMMEDIATE FAMILY MEMBER* EVER HAD A PHLEBITIS?	☐ YES	☐ NO
ARE *YOU* CURRENTLY ON A PRESCRIBED BLOOD THINNER THAT YOU ARE AWARE OF?	☐ YES	☐ NO
DO *YOU* HAVE ANY CARDIAC STENTS?	☐ YES	☐ NO
HAVE *YOU* BEEN DIAGNOSED WITH KIDNEY FAILURE?	☐ YES	☐ NO
HAVE *YOU* BEEN DIAGNOSED WITH BLEEDING ULCERS?	☐ YES	☐ NO
DO *YOU* HAVE TROUBLE TOLERATING OR HAVE YOU BEEN TOLD NOT TO TAKE ASPIRIN?	☐ YES	☐ NO
DO *YOU* HAVE A HISTORY OF SEIZURE DISORDERS?	☐ YES	☐ NO
HAVE *YOU* BEEN DIAGNOSED WITH DEPRESSION?	☐ YES	☐ NO
HAVE *YOU* BEEN DIAGNOSED WITH AN ANXIETY DISORDER?	☐ YES	☐ NO
HAVE *YOU* BEEN DIAGNOSED WITH LIVER FAILURE?	☐ YES	☐ NO
HAVE *YOU* BEEN DIAGNOSED WITH HIV / AIDS?	☐ YES	☐ NO
HAVE *YOU* EVER BEEN DIAGNOSED WITH HEPATITIS?	☐ YES	☐ NO
HAVE *YOU* BEEN DIAGNOSED WITH DIABETES?	☐ YES	☐ NO
HAVE *YOU* BEEN DIAGNOSED WITH HEART FAILURE?	☐ YES	☐ NO
HAVE *YOU* EVER HAD A TRANSIENT ISCHEMIC ATTACK (TIA)?	☐ YES	☐ NO
HAVE *YOU* EVER HAD A STROKE?	☐ YES	☐ NO
DO *YOU* HAVE A HISTORY OF ANESTHESIA COMPLICATIONS?	☐ YES	☐ NO
DO *YOU* WORK IN HEALTH CARE OR HAVE EXPOSURE TO MRSA?	☐ YES	☐ NO
DO *YOU* HAVE A HISTORY OF MRSA (STAPH) INFECTION?	☐ YES	☐ NO
DO *YOU* HAVE A HISTORY OF INFECTION AFTER SURGERY?	☐ YES	☐ NO
HAVE *YOU HAD TROUBLE HEALING AFTER PREVIOUS SURGERIES OR INJURIES*?	☐ YES	☐ NO
ARE *YOU* AN ORGAN TRANSPLANT RECIPIENT?	☐ YES	☐ NO
HAVE *YOU* HAD A PREVIOUS SURGERY ON THE OPERATIVE JOINT?	☐ YES	☐ NO
DO *YOU* BEEN ON STEROIDS FOR A LONG TIME (PREDNISONE, CORTISONE……..)?	☐ YES	☐ NO
HAVE *YOU* HAD A STEROID INJECTION ON THE OPERATIVE JOINT IN THE PAST 90 DAYS?	☐ YES	☐ NO
DO *YOU* USE TOBACCO PRODUCTS (ORAL TOBACCO, VAPING, CIGARS, CIGARETTES…)	☐ YES	☐ NO
IF YES, ARE *YOU* WILLING TO QUIT?	☐ YES	☐ NO
DO *YOU* HAVE AN ALLERGY TO TOPICAL IODINE?	☐ YES	☐ NO
DO *YOU* HAVE AN ALLERGY TO LATEX?	☐ YES	☐ NO
HAVE YOU HAD AN INFLUENZA VACCINE THIS YEAR? DATE:_____	☐ YES	☐ NO
HAVE YOU HAD A PNEUMONIA VACCINE THIS YEAR? DATE:_____	☐ YES	☐ NO
HAVE *YOU* BEEN DIAGNOSED WITH CANCER IN THE PAST 5 YEARS?	☐ YES	☐ NO

If yes, please provide the following information:

Type of cancer:_____ Date of Diagnosis:_____

Did you require any of these treatment(s)?

☐ Radiation Therapy Location:_____

☐ Chemotherapy Type:_____

☐ Lymph Node Removal Location:_____

Oklahoma Joint
Reconstruction Institute
Paul B. Jacob, DO

INFORMED CONSENT FOR TELEHEALTH TREATMENT

Prior to your telehealth visit, please read the below consent for telehealth treatment.

1. You retain the option to withhold or withdraw consent at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

2. The laws that protect the confidentiality of your medical information also apply to telehealth. The information disclosed by you during the course of your treatment is generally confidential.

   Exceptions to confidentiality laws include the requirements to: *Protect you or the public from serious harm; report abuse or neglect of children, the elderly, or people with disabilities; and respond to an order from a court or other valid legal process such as a subpoena.*

3. There is a possibility that transmission of your medical information could be disrupted or distorted by technical failures; the transmission of your medical information could be interrupted by unauthorized persons; and/or misunderstandings between you and your provider can more easily occur.

4. Telehealth-based services and care may not yield the same results as a face-to-face service. If you or your provider believes you would be better served by face-to-face service, you may be referred to a provider in your area to receive such service.

5. There are potential risks associated with any form of mental or physical treatment for medical conditions, and despite your efforts and the efforts of your provider, your condition may not improve, and in some cases may even get worse.

6. The benefits of telehealth may include removing transportation and travel barriers, minimizing time constraints, and providing greater opportunity to prepare in advance for treatment sessions.

7. All existing laws regarding access to your medical information and copies of medical records apply.

8. You agree not to record or share the content of your telehealth visit.

9. You agree to conduct the visit in a private space without any unwanted attendee's present, or able to hear or see your visit, unless an alternative arrangement is agreed to by you and your provider.

10. If an unauthorized individual comes into the room during your visit, pause your phone call and restart only after they have left.

_____

Signature of Patient or Legal Representative **Print Name** **Date**

_____

Witness Signature **Print Name** **Date**

_____

Dr. Paul B. Jacob **Date**

Oklahoma Joint Reconstruction Institute

Paul B. Jacob, DO

Metal Allergy Informed Consent

Metal Sensitivity or Metal Allergy

Metal Sensitivity (also called metal hypersensitivity or metal allergy) is a form of an allergic reaction and can be caused by exposure to metals in jewelry, dental implants and **orthopedic implants**.

Implants Contain Metal

The metal hip or knee implants themselves will not likely be the cause of a reaction. In older, poorly functioning "metal-on-metal" joint implants, where the metal ends of the implants are in contact, large quantities of metal could be released inside the joint. If you have a metal allergy, and metal particles are present in your joint, then that may play a role in failure of the joint replacement. In implants with plastic parts, wear of the plastic may over time lead to unintended wear of metal against metal. This happens in poorly-functioning joint replacements and generally takes several years to occur. **Typically, well-functioning joint replacements do not lead to deterioration of the implants and generation of metal particles.**

Testing for Metal Allergy

In the past, skin patch testing was used to help diagnose a metal allergy; however, research has shown a skin test that is positive for metal allergy does not necessarily mean you will have complications with your joint replacement. Blood tests are available to check for metal sensitivity, but these tests also ***are not*** the best predictors of whether or not your joint replacement will have complications. Metal-LTT is a blood test which tests immune cell responses to different metals. Metal-LTT testing can identify which people are susceptible to metal sensitivity. Metal-LTT testing can also identify which specific metals cause sensitivity responses and which specific metals do not cause excessive immune reactions. Determining the right kind of metal implant for a metal sensitivity person can only be accomplished when the specific metals an individual is reactive to can be diagnosed. **It is important to remember that routine skin or blood tests to check for metal allergy/sensitivity is not recommended by the American Academy of Hip and Knee Surgeons or the American Academy of Orthopedic Surgeons since there is still not enough evidence to suggest these are helpful.**

Signs of Metal Sensitivity Before Surgery

Common symptoms of a metal allergy conditions are skin hives, rashes, local skin redness, swelling, and itching. Other symptoms include inflammation and pain associated with a metal orthopedic or dental implant where infection and other causes of inflammation ***have been ruled out***. If you have had skin reactions to jewelry (rings, necklaces, earrings, etc.) or eyeglasses, this may be an indication to obtain metal sensitivity testing but often ***does not*** corelate with positive results. In addition, patients who work with or around metals can develop a sensitivity. Let your surgeon know before you schedule your surgery if your work with metals frequently or if you have had reactions to jewelry or metals that come in contact with your skin.

Allergic or Sensitive to Metal

Generally, the amounts of metal exposure to cause allergic responses are below the concentrations that cause toxicity. Metal ions that are released from metal implants can produce sensitivity responses by attaching to circulating proteins and changing them enough to activate the immune system. Metals that are common sensitizers include **nickel, cobalt and chromium**, where **10-15% of people** are allergic to one or more of those three metals. If you think you are allergic or sensitive to metal, then it is important to alert your surgeon prior to having joint replacement surgery. While 10-15% of people will have some reaction to certain metal allergy tests, **metal allergy is a very rare cause of failure in knee replacements.**

Signs of Metal Allergy after Surgery

The diagnosis of a metal allergy after surgery is very challenging. The symptoms may include skin rash, itching and discoloration in the area around the artificial joint. Other symptoms such as joint pain, swelling, and joint stiffness can have numerous causes and not necessarily be because of a metal allergy/sensitivity. If you develop a skin reaction near the location of your hip or knee implants, steroids or topical creams can be used for mild symptoms.

Revision Surgery

A second surgery, called "revision," to non-allergenic implants is generally not needed and should be considered only as a last resort. Because diagnosing metal allergy after surgery cannot be done with 100% certainty, the outcomes of a revision surgery are ***unpredictable at best***. It is exceedingly rare to have a hip or knee replacement fail because of metal sensitivity or allergy.

Ortho Analysis LLC

Oklahoma Joint Reconstruction Institute and Dr. Paul B. Jacob use **Orthopedic Analysis** to perform metal allergy testing on patients.

Ortho Analysis LLC has been in operation since 2005, founded by Dr Nadim James Hallab (CEO), a Professor in the Department of Orthopedics, Department of Cell Biology/Anatomy and Department of Immunology at Rush University Medical Center in Chicago.

This company was formed after the utility of metal-LTT testing was demonstrated in over 10 years of scientific study and publication in top ranked peer-reviewed US journals. And the subsequent request of orthopedic surgeons from around the USA to conduct this testing for them.

The chief scientist Dr Marco Steve Caicedo (COO) is a well published Immunologist with nationally known expertise in immune reactivity to non-biological materials. Orthopedic Analysis aims to provide diagnostic services both nationally and internationally.

Payment

Orthopedic Analysis does not bill insurance companies and payment in full is required once the sample arrives at their facility. **The cost of the test is $573.00** paid directly to Orthopedic analysis. Payment can be made by attaching a check, money order or credit card information on the requisition form included in the kit. You can also pay online with a credit card. It is important to know that Oklahoma Joint Reconstruction does not affiliate in any way with orthopedic analysis. Nor, does Oklahoma Joint Reconstruction Institute receive any reimbursement for this testing. This is a direct interaction between the patient and the lab itself. Orthopedic Analysis will provide you with a copy of your results and an itemized paid invoice (including their procedure code) that you can submit to your insurance company and seek reimbursement for the test

Private insurance reimbursement for the testing varies greatly depending upon the individual's healthcare plan. It is also based on medical necessity. While some patients are routinely fully reimbursed, others have received partial reimbursement or no reimbursement at all.

Metal Allergy Testing Informed Consent

I _____ have read the aforementioned documentation of metal allergy and confirm understanding.

The general nature and purpose of the testing has been explained to me as well as the proposed treatment(s), procedure(s), as well as the potential risks, and the reasonable alternatives.

I understand that if I choose to waive metal allergy testing offered by OJRI at this time, I am taking the risk that I may have unforeseen issues with my joint replacement postoperatively due to possible metal allergy.

I choose to do the following:

- ☐ Waive undergoing metal allergy testing offered by OJRI
- ☐ Submit to metal allergy testing offered by OJRI

Signature Patient	Printed Name	Date

Staff Witness	Printed Name	Date

Dr. Paul Jacob		Date

Metal Testing Results

How will your results be reported?
Your results will be reported in three categories:

1) ***Normal*** - Anything below a stimulation index of 2.

2) ***Mild (Mild reaction)*** – A Stimulation Index between 2 and 4. This is considered a sub-clinical reaction that is unlikely to affect your sort term or long term outcome. You will receive *standard cobalt chrome and/or titanium implants.*

3) ***Reactive (moderate reaction)*** – A Stimulation Index between 4 and 8. This is considered a clinically relevant reaction that has a low potential to affect your short term and/or long term outcome. You will receive an *implant that avoids the use of the substances you were reactive to.*

4) ***Highly Reactive (severe reaction)*** - A Stimulation index above 8. This is considered a clinically relevant reaction that has the potential to affect your short term and/or long term outcome. *You will receive an implant that avoids the use of the substances you were reactive to.*

What is the Known Stimulant (PHA)?
The **Known Stimulant (PHA)** is the measurement of the reaction to a substance that will strongly stimulate your immune system. It is the standard to which your responses (mild, reactive, and highly reactive) are measured for clinical relevance. A proliferation index (or stimulation index) is a number measurement of how much proliferation happens when immune cells are exposed to each metal.
The proliferation index (or stimulation index) is simply a measure of how many more times metal-treated immune cells (lymphocytes) have proliferated when compared to that same person's immune cells that were not treated with anything (non-challenged).

How are the results sent to me?
An example of the results sent out are shown in figure below. The amount of each person's immune reactivity (stimulation index) to each of the metals tested for are calculated and put in graphical form, like the one below, and the results are sent out to whomever the patient has indicated (self and / or physician).

Are these results private?
Privacy is our top priority. No one has the right to see your results except you and whoever you want to see them. Your results are only sent to whomever you (the person tested) wants them sent to and in the way they want them sent (email, fax or regular mail).

What is and is not reactive?
Although anything above 2 is generally considered a mild response, if the reactivity is between 2 and 4 (not statistically significant) then the reaction is considered sub-clinical and does not limit your choices. Thus, the amount of reactivity has been broken down into 3 ranges, mild, reactive, and highly reactive. If you are in the ***reactive or highly reactive*** ranges then I would recommend avoiding that material in your construct.

References

1) Bergschmidt P, Bader R, Mittelmeier W. Metal hypersensitivity in total knee arthroplasty: revision surgery using a ceramic femoral component – a case report. *Knee* 2012 Mar:19(2): 144-7
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3) D. A. Basketter, et al, Contact Dermatitis 28, 15 (1993).
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5) Innocenti M, Carulli C, Matassi F, Carossino AM, Brandi ML, Civinini R. Total knee arthroplasty in patients with hypersensitivity to metals. *Int Ortho.* 38(2014):329-33.
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8) Merritt K, Brown SA. Metal sensitivity reactions to orthopedic implants. *Int J Dermatol.* 1981 Mar;20(2):89-94
9) P. Haudrechy, J. Foussereau, B. Mantout, B. Baroux, Contact Dermatitis 31, 249 (1994).
10) Thyssen JP, Menne T, Schalock PC, Taylor JS, Maibach HI. Pragmatic approach to the clinical work-up of patients with putative allergic disease to metallic orthopaedic implants before and after surgery. *Br J Dermatol.* 2011 Mar;164(3):473-8.

SAMPLE

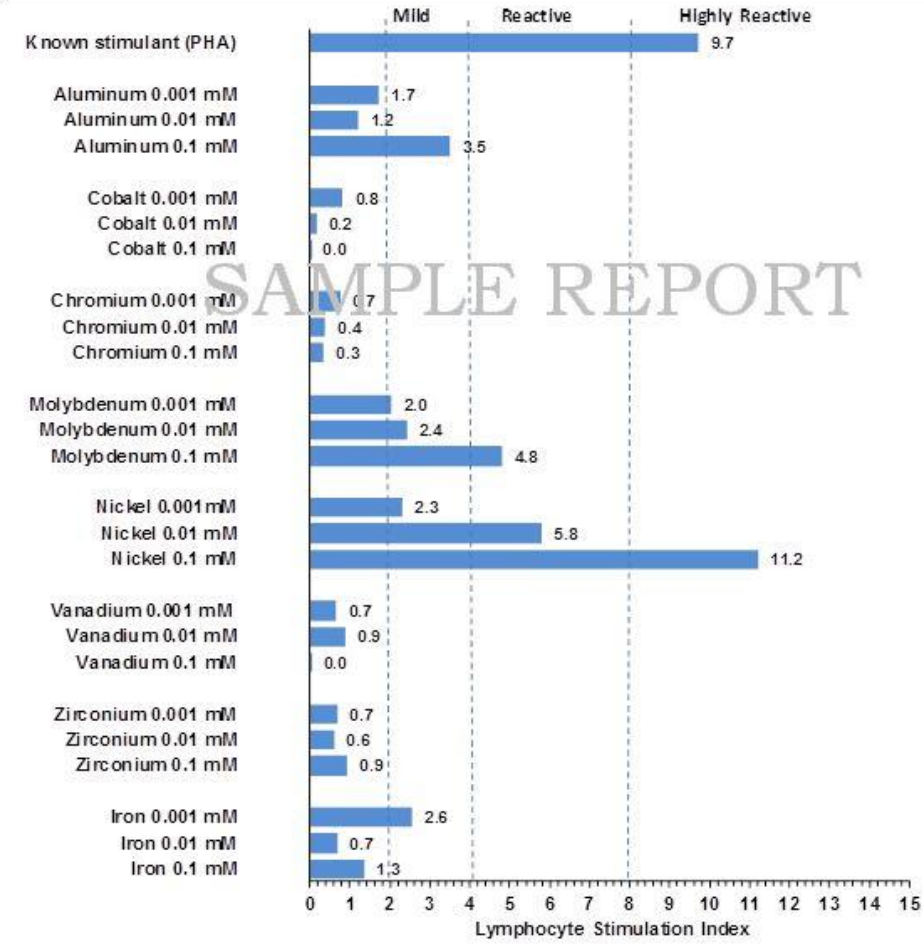
ORTHOPEDIC ANALYSIS

Metal-LTT Analysis Report

Panel 1

Report Date	1/1/2011		
Report Time	12:00 AM	Sample Collected 1/1/2011	
Patient ID	1234	Sample Received 1/1/2011	10:00 AM
Report For	Doe, John	DOB xx/xx/xx	
Attending Physician	Dr. X		

Control cpm	3122.0
Positive control (PHA) cpm	30358.3



Mildly Reactive	2 to 4
Reactive	4 to 8
Highly Reactive	above 8

2201 W. Campbell Park Drive. Suite 211 Chicago, IL 60612
www.orthopedicanalysis.com
Results by: MC
p: (312) 733-7121

RESULTS

Operating Principle: Metal-induced immune response = Increased Lymphocyte Proliferation

Oklahoma Joint Reconstruction Institute

Paul B. Jacob, DO

SOAPP Version 1.0 - SF

Name: _____ Date: _____

The following are some questions given to all patients at the Oklahoma Joint Reconstruction Institute who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

Please answer the questions using the following scale:	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
	0	1	2	3	4
1. How often do you have mood swings?	☐	☐	☐	☐	☐
2. How often do you smoke a cigarette within an hour after you wake up?	☐	☐	☐	☐	☐
3. How often have you taken medication other than the way that it was prescribed?	☐	☐	☐	☐	☐
4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	☐	☐	☐	☐	☐
5. How often, in your lifetime, have you had legal problems or been arrested?	☐	☐	☐	☐	☐

Oklahoma Joint
Reconstruction Institute
Paul B. Jacob, DO

New State Law Regarding Narcotic Prescriptions
House Bill 2931
Effective January 1, 2020

Print Name: _____ Date of Birth: _____

Due to a new State of Oklahoma law, all narcotic medications **MUST** be sent to pharmacies in electronic form **ONLY**. Handwritten narcotic prescripts are no longer acceptable under this new law.

Please provide your pharmacy information below. **This is the only pharmacy we will use for your medications.** If you need a refill, you will be required to contact our office 48-72 hours in advance.

Since our physicians are often in surgery and not in the clinic setting, same-day or next day refills **cannot** be guaranteed.

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Confirm the above information is correct. As this is where you will be required to pick up your prescription.

IF YOU ARE ALREADY UNDER A PAIN CONTRACT:

If you already have a pain management contract with another physician, please provide us with contact information so that we can appropriately inform them of your temporary change in pain control physicians.

☐ My pain management physician will be prescribing my post-operative pain control medications.

Physician name and specialty:
☐ Family Physician:_____
☐ Pain Management:_____
☐ Other:_____

Physician Address: _____

Physician Phone Number: _____

9800 Broadway Ext. Suite 201 ● Oklahoma City, Oklahoma 73114 ● Phone (405) 424-5426 ● Fax (405) 424-5431
www.OJRI.com ● www.drpauljacob.com ● www.robotichipandkneereplacement.com ● www.jointsensor.com

Oklahoma Joint Reconstruction Institute
Paul B. Jacob, DO

OPIOID THERAPY INFORMED CONSENT FOR TREATMENT

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. It is also meant to prevent misunderstandings about certain medicines the patient will be taking for pain management. This is to help both the patients and their provider comply with the law regarding post-surgery pain management. Please read this contract thoroughly as it is a condition of any treatment requiring narcotic pain medication or other controlled substances. Your signature will also be required prior to initiating any treatment involving controlled substances.

Our goal is to provide you with the best quality treatment of your pain. To accomplish this goal, your physician will customize your treatment plan to best fit your healthcare needs. Your pain management treatment plan may include, but is not limited to, injection therapy, physical therapy, medication therapy, psychological counseling, relaxation therapy and exercise and weight loss programs. When opioids and other controlled medications are the best option, it is important to review and follow the policies to ensure your safety and our continued ability to treat you in the most effective way possible.

Please read this carefully, as these policies will be enforced. If you do not understand any of the information below or require additional clarification on the policies of this practice regarding prescribed medication, please ask prior to signing the agreement. You are required to sign this agreement stating your understanding and compliance before receiving any pain medication.

Dr. Jacob and his physician assistants ***do not*** prescribe pre-operative opioid based pain medication. If you require pre-operative opioid based pain medication prior to your surgery, this needs to come from your pain management provider or your primary care physician. We will provide you with prescriptions for your pain medications per the rules set forth on your pain contract for a **maximum** of 90 days post-operatively. This does not guarantee that you will receive pain medication for 90 days. If you require pain medication beyond the allotted time frame you will be referred to back to your primary care physician or a pain management physician for ongoing pain management needs.

You understand that opioids and other controlled medications are prescribed to increase your function, activity level and quality of life. These medications may reduce your pain but may not provide complete relief. Your treatment plan will be evaluated, at least, every three months. You agree to fully communicate your pain level, functional ability and any side effects of the medication to the best of your ability. If these aspects do not improve with these medications, the risks of the medication outweigh the benefits or there is the potential of negative effects related to another medical condition or medication, your provider may reduce or eliminate the medications from your treatment plan.

You agree to inform your physician of all medications you are taking, including herbal remedies, since Opioid medications can interact with over-the-counter medications and other prescribed medications. This is especially true of cough syrup that contains alcohol, codeine or hydrocodone.

To ensure your safety, **it is your obligation and responsibility to take medications exactly as prescribed by your physician** (dose and frequency). You understand that these medications can lead to physical dependence and/or addiction, and can be associated with other risks including, but not limited to, decreased effectiveness, physical and psychological dependence, confusion, itching, difficulty urinating, constipation, allergic reactions, decreased sex drive, drowsiness, nausea or vomiting, trouble driving and/or operating machinery. Taking more opioids than prescribed or mixing sedatives, benzodiazepines, sleep medications, or alcohol with opioids can result in fatal respiratory depression.

You agree **to only take pain medications prescribed by Dr. Jacob or his covering physicians and/or partners**. Do not take any pain medication given to you by another person or provider (health, dental, clinic or emergency department) or increase your dosage without authorization from this physician. You understand that taking more medication than prescribed or taking pain medication from another source may lead to **overdose** that could result in slowed or stopped breathing, brain injury from lack of oxygen, coma, or death.

You understand that there is an increased risk of overdose associated with the use of opioids in combination with medications used to treat anxiety disorders, panic attacks, insomnia or seizures (benzodiazepines), alcohol and other central nervous system depressants. If you are prescribed these medications by another provider at any time during your pain management treatment, you must inform your physician immediately. You must also inform all other treating healthcare providers of the medications being prescribed as a part of your pain management treatment plan.

You understand this clinic has a policy of limiting dosing to a maximum of ***100mg of Morphine or equivalent maximum doses as outlined in the CDC Opioid Treatment Guidelines and Oklahoma state law***. You agree to comply with such policies and dosing limitations.

You understand addiction is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. If you have a history of alcohol or drug misuse/addiction, you must notify the physician of such history.
You understand your medications are required to last for the duration prescribed. You must safeguard and protect your prescription medications, including keeping them in a safe place and away from children. It is recommended you keep them in a locked safe or cabinet. You must not share, sell or otherwise permit others to have access to these medications. If you fail to meet this prescribed timeline, your medication is lost, misplaced, destroyed or stolen, **early prescription refills will not be permitted.** This physician reserves the right to choose to taper or discontinue medications that are lost or stolen.

9800 Broadway Ext. Suite 201 ● Oklahoma City, Oklahoma 73114 ● Phone (405) 424-5426 ● Fax (405) 424-5431
www.OJRI.com ● www.drpauljacob.com ● www.robotichipandkneereplacement.com ● www.jointsensor.com

If you intend to stop taking your medications, have a negative reaction, or fail to submit your prescription refill request according to the policies below, you must discuss this discontinuation of medications with your physician prior to doing so. Sudden discontinuation of medications may result in withdrawal, including nausea, shakiness, sweating, rapid heart rate, diarrhea, high blood pressure, pain or severe nervousness. If your physician discontinues your medications as a part of the treatment plan, non-compliance or dismissal from the practice, you will be provided with a weaning or tapering dose to avoid negative withdrawal effects.

All prescriptions will be obtained at **one pharmacy**, when possible. Should the need to change pharmacies arise, you must inform our office immediately.

In the event of a new injury or significant change in your condition, please call our office to make an appointment. In the case of a true medical emergency, please go directly to the ER or call 911. Patients are responsible for notifying any other doctor they see that they obtain narcotics from this office. Patients are responsible for notifying this office of any treatment received by the ER or another physician. If you see another doctor who gives you a controlled substance medicine (a dentist, a doctor from the Emergency Room, another doctor, etc.), you must notify your doctor. I am not to seek or accept medications from other providers without my doctor's permission, except in the event of a true medical emergency in which case, I must notify my doctor as soon as possible.

The prescribing physician and staff have permission to discuss history, diagnosis and treatment details with dispensing pharmacists or other professionals who provide you healthcare.

This clinic and/or physician retains the right to discuss your treatment with law enforcement officials during any official investigation.

You agree to read the package inserts and prescription bottle labels for any prescribed medications. You will discuss any questions or concerns regarding contraindications or reactions with your physician. You will inform this clinic, immediately, if you have a reaction or are allergic to any prescribed medication.

You will be asked to obtain a Narcan or opioid "overdose kit", available from local pharmacies without a prescription. Failure to comply may result in discontinuation of medication.

(Female Patients Only) To the best of your knowledge, you are NOT pregnant. You agree to use appropriate contraceptive during your course of treatment. **If you do become pregnant or suspect pregnancy, you will notify your physician IMMEDIATELY.** You understand there are potential *****risks associated with pregnancy and chronic opioid therapy. You or your unborn child may experience significant or serious side effects related to the medications you are prescribed.

***(Patients Currently Pregnant) The short-term use of opioids for acute pain can be safe when prescribed by your physician. Long-term use of opioids can be harmful for your unborn baby. There is also a risk of neonatal abstinence syndrome with use of opioids that can require in-hospital treatment of the baby after birth. You should discuss alternatives to opioids for pain control, but non-steroidal anti-inflammatory drugs should not be used in the third trimester of pregnancy.**

You must keep your scheduled appointments. If you are unable to make it to an appointment, please provide 24-hour notice to cancel. **If you fail to appear or give the requested notice of cancellation, your medications may not be refilled**. If you fail to appear for more than 2 appointments, you may be dismissed from our practice.

You understand that if anytime, your provider has reason to believe that you are not in compliance with the terms of this agreement or your treatment plan, the provider may terminate this agreement and medications with a proper weaning dose. If you wish to terminate this agreement, please contact our office for guidance.

Your health care team is dedicated to your safety and the control of your pain, and we must have your cooperation to achieve these goals. The agreement is designed to ensure your safety and to help us and you comply with the standards of good medical care, as well as, state and federal laws related to chronic opioid therapy. Please sign below.

SUMMARY OF INFORMED CONSENT:

- All prescriptions must be sent electronically per state law. No paper prescriptions will be issued.
- Pain medication will only be prescribed for a maximum of 90 days post-operatively.
- **You are not guaranteed pain medication during this time period**
- If continued pain management is needed after this time, you will be referred for further care.
- You may not share, sell, or trade my medicine.
- I agree not to take any medicine not prescribed to me.
- Forging or altering a narcotic prescription or distributing medications to others is a crime.
- Excessive phone calls requesting increased dosages or frequency is viewed as drug-seeking behavior.
- Changes in medication will not be made without an office visit.
- You will not increase your medicine without speaking with Dr. Jacob or one of his physician assistants.
- Your medicine will not be replaced if it is lost, stolen, or used up sooner than prescribed.
- You will keep all appointments set up by your doctor.
- You will notify your doctor's office at least 24 hours prior to your scheduled appointment if you must cancel.
- Multiple cancellations, no-shows, or rescheduled appointments is considered non-compliance and may result in dismissal.
- You will bring the pill bottles with any remaining pills of this medicine to each clinic visit if requested.
- You agree to come to the office for a pill count at any time if asked by my doctor.
- You agree that you will not use any illegal substances.
- You understand that your doctor's office will use the Oklahoma Bureau of Narcotics Drug Tracking Program as required by law.
- You have been informed by your doctor about narcotic effects, including the normal physiological effects of tolerance (where you might need to take more medication to obtain the same pain relief) and dependence (an uncomfortable withdrawal reaction which may occur if you stop taking medication abruptly), and the abnormal effects of addiction (psychological dependence leading to abnormal behavior).
- You understand that narcotics can adversely affect your judgment in making business decisions and in operating equipment such as an automobile.

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- You understand that refills of narcotic medication will be given only during my regularly scheduled appointments or, when appropriate, by telephone if the current prescription has been correctly used.
- You will only use one pharmacy to get your medicine. Your doctor may talk with the pharmacist about your medicines.

PRESCRIPTION REFILL POLICIES:

- You understand that you **must be assessed by our providers prior to every opioid prescription refill**.
- Refill requests are only accepted Monday – Friday from 8:00 AM to 3:30 PM **No exceptions will be made.**
- **No refill requests will be accepted AFTER 3:30 PM**
- **No refill requests will be accepted on SATURDAYS or SUNDAYS**
- **No refill requests will be accepted ON HOLIDAYS**
- You understand that IT IS **YOUR RESPONSIBILITY** to monitor your pain medication. **Early refills are not permitted**
- You understand that IT IS **YOUR RESPONSIBILITY** to check with your pharmacy to confirm your refill is ready for pick-up
- You must inform your provider of any changes in other prescribed or OTC medications, medical condition, surgical history, relevant family history, social history, or civil actions related to the use of opioids, narcotics, alcohol, or illegal substances.
- You agree to comply with **medication compliance monitoring** as needed. These include, but are not limited to:

- **Random pill counts** may be required and must be responded to within the given timeframe. If you live outside of a 60-mile radius from our office, your local pharmacy or doctor's office may perform the requested pill count and report the results to our office. Counts that are inconsistent or failure to comply with a requested pill count will be viewed as non-compliance and may result in dismissal from this practice.
- **Random urine or blood drug screenings** may be requested. Presence of illegal, unauthorized substances, absence of prescribed medications or other abnormal results may result in discontinuation of your controlled medications. Failure or refusal to provide a sample for drug testing will be viewed as non-compliance and may result in dismissal from our practice.
- Should any of the above occur, my entire care with this office will be terminated and I will be reported to law enforcement.

Emergencies
In the event of a new injury or significant change in your condition, please call our office to make an appointment. In the case of a true medical emergency, please go directly to the ER or call 911. Patients are responsible for notifying any other physician they see that they obtain opioids from this office. Patients are responsible for notifying this office of any treatment received by the ER or another physician. Patients must notify this office if opioids have been obtained from another physician.

Prescriptions from Other Doctors
If I see another doctor who gives me a controlled substance medicine (a dentist, a doctor from the Emergency Room, another doctor, etc.), I must bring this medicine to the office in the original bottle, even if there are no pills left. I am not to seek or accept medications from other providers without my doctor's permission.

Termination of Agreement
If I break any of the rules, if my drug test results are inconsistent with treatment prescribed by my doctors, or if my doctor decides that this medicine is hurting me more than helping me, this medicine will be stopped by my doctor in a safe way and no refills will be made. Further, my physician may dismiss me as a patient of the practice and ask me to select another physician. Any violation of this contract or counseling received regarding violations will remain a part of my permanent medical record. This contract will remain enforced during the entire course of my treatment plan.

INFORMED CONSENT

I, _____, have been informed and clearly understand the above listed issues regarding the treatment of pain with opioid pain medications for both acute and chronic conditions. I acknowledge that I have read and understand this agreement. The pain management treatment plan has been discussed, understood, and agreed to myself and my physician. All questions or concerns have been answered or addressed to my satisfaction. I also understand that I have the right to talk about this agreement with my physician. I understand the reason why this prescription is necessary, the alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me and I still desire to receive medications for the treatment of my pain. I agree to comply with the terms contained herein and understand that failure to do so may result in termination of the physician/patient relationship and/or termination from this medical practice. I understand that this agreement will be filed in my chart as part of my permanent medical record.

Patient Signature	Patient Printed Name	Date
Witness Signature	Witness Printed Name	Date
Dr. Paul B. Jacob		Date

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Oklahoma Joint Reconstruction Institute
Paul B. Jacob, DO

PATIENT-PROVIDER AGREEMENT FOR ACUTE PAIN TREATMENT

Acute Pain Definition: Pain, whether resulting from disease, accidental or intentional trauma, surgery or other cause, that the practitioner reasonably expects to last only a short period of time. "Acute pain" does not include chronic pain, pain being treated as part of cancer care, hospice or other end-of-life care, or pain being treated as part of palliative care. The state of Oklahoma defines this period of time to last a maximum of two weeks.

I agree to the following:

1. Your treating physician has prescribed you opioid pain medication as part of your treatment plan to manage your acute pain.
2. The pain you are experiencing may be improved, but not eliminated, with the use of these opioid medications. Opioids are a type of powerful pain medication often called narcotics. They can be very useful in managing pain but have a high potential for dependency and addiction.
3. Once opioid pain medications are prescribed, you will be required to have regular office visits to assess your pain status and monitor your compliance with this agreement. Your medications will not be phoned in should you be unable to keep these appointments.
4. Pain medications are strictly for your own use. The medication should not be given or sold to others because it may endanger that person's health and it is against the law.
5. This office fills pain medications for surgical patients only. They are not filled indefinitely. Your doctor will taper your medications for discontinuation. If discontinuation is not possible, or you are not a surgical candidate, you will be referred for long-term pain management.
6. Your treating physician is to be the only physician who prescribes opioid pain medications to you unless otherwise approved by the treating physician.
7. It is your responsibility to notify us of any other physician who is prescribing opioid pain medications to you. It is also your responsibility to inform other physicians that we are prescribing and managing your opioid pain medications.
8. Individuals must be aware that "doctor shopping" is viewed as narcotic drug seeking behavior and is not tolerated. Should this type of behavior occur, your opioid pain medications will not be refilled, and you will be dismissed as a patient.
9. Excessive calls requesting pain medications, or an increase in the dose or frequency of your pain medications is viewed as drug seeking behavior and is not tolerated. You will be asked to make an appointment to see the doctor before any changes are made.
10. Pain medication refill request are taken and called in MONDAY through Friday from 8:00 AM to 3:30 PM ONLY. **PRESCRIPTION REFILLS ARE NOT TAKEN OR CALLED IN ON SATURDAY, SUNDAY, HOLIDAYS OR AFTER HOURS FOR ANY REASON.**
11. Opioid medications carry a high potential for abuse and addiction. Therefore, federal and state law carefully regulates dispensed or written prescriptions for opioid medications. Forging or altering an opioid prescription, or distribution medications to others for their use or for money, is a crime. Such behavior is not tolerated. You will be dismissed as a patient and reported to appropriate authorities.
12. Lost, stolen or misplaced prescription medications ARE NEVER REPLACED – NO EXCEPTIONS. Your medications and prescriptions are your responsibility. You should store opioid medications in a secure location to prevent others from taking them and safely dispose of them when you are no longer using them.
13. There are several risks of opioid medications that your treating physician has discussed with you. Some of those risks include sleepiness or drowsiness, impaired mental or motor ability, slowing of breathing rate, skin rash, constipation, sexual dysfunction, sleep abnormalities, sweating, swelling, physical or psychological dependence, tolerance to analgesia (meaning you require more medicine to get the same pain relief), and addiction. Opioid medications are highly addictive even when taken as prescribed. Overdose of opioid pain medication can lead to breathing difficulty and even death. Taking more opioid medication than prescribed or mixing opioid medication with alcohol, sedatives, benzodiazepines, and other central nervous system depressants is highly dangerous and can be fatal. It is your responsibility to inform your treating physician about all other medicines you are taking.
14. You should not drive an automobile or operate any machinery when taking opioid medications.
15. Your treating physician has discussed with you alternative pain management approaches that may be available to manage your pain instead of taking opioid pain medications and the risks and benefits of the alternatives.
16. If you break any of the rules described in this agreement, or your physician decides that the medicine is hurting you more than helping you, this medicine will be stopped by your physician in a safe way and no refills will be made. Further, your physician may dismiss you as a patient of the practice and ask you to select another physician. Any violation of this agreement or counseling received regarding violations will remain a part of your permanent medical record. This agreement will remain enforced during the entire course of your treatment plan.

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- You must inform your provider of any changes in other prescribed or OTC medications, medical condition, surgical history, relevant family history, social history, or civil actions related to the use of opioids, narcotics, alcohol, or illegal substances.
- You agree to comply with **medication compliance monitoring** as needed. These include, but are not limited to:

- **Random pill counts** may be required and must be responded to within the given timeframe. If you live outside of a 60-mile radius from our office, your local pharmacy or doctor's office may perform the requested pill count and report the results to our office. Counts that are inconsistent or failure to comply with a requested pill count will be viewed as non-compliance and may result in dismissal from this practice.
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Patient Signature	Patient Printed Name	Date
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Print Form Email Form Clear Form

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