OSAMA ELSHAZLY, MD
REGISTRATION FORM

Today's Date_____ (PLEASE PRINT)

PATIENT INFORMATION

Name _____ Birth date _____ Age _____

Address _____ City, State, Zip _____

Home Phone # _____ Cell # _____ Work # _____

Email _____ **SSN** _____

⇛ Male ⇛ Female Status: ⇛ Single ⇛ Married ⇛ Divorced ⇛ Widowed ⇛ Separated

Employer _____ Occupation _____

Work Address _____ City, State, Zip _____

Emergency Contact _____ Relationship _____ Phone _____

PRIMARY INSURANCE

Insurance Company _____ Policy # _____ Effective Date _____

Name of Insured (Primary Member) _____ **DOB** _____

Insured's **SS#** _____ Relationship to Patient _____

Insured's Address _____ City, State, Zip _____

Employer _____ Occupation _____

Work Address _____ Work phone # _____

SECONDARY INSURANCE

Insurance Company _____ Policy # _____ Effective Date _____

Name of Insured _____ DOB _____

ASSIGNMENT & RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the insurance company listed above and assign directly to **Osama Elshazly, MD** all insurance benefits, if any, otherwise payable to me for services rendered. *I understand that I am financially responsible for all charges whether or not paid by insurance.* I hereby authorize Dr. Elshazly to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance claims and submissions.

_____ _____ _____

Patient or Guarantor Signature | Relationship to Insured | Date

Clinical Opiate Withdrawal Scale (COWS)*[1,2]

For Clinicians Treating Opioid Addiction and Those Evaluating Potential Opioid Abuse in Selected Patients[1]

This scale can be used by clinicians to assess an individual's physical dependence on opioids by rating 11 common signs or symptoms of opioid withdrawal. The scale can be applied to patients in a variety of office, hospital, and clinical settings. The COWS can be used to evaluate possible withdrawal symptoms in patients suffering from opioid addiction. It can be administered to track changes in the severity of opiate withdrawal symptoms over time or in response to treatment.

Patient's Name: _____ **Date and Time:** ___/___/___ : ___

Reason for this assessment: _____

Resting Pulse Rate: _____ beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset:** *over last ½ hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past ½ hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 No tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

*The COWS may not be the only scale available. Provided for informational purposes only.

References: 1. Wesson DR, Ling W. The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs.* 2003 Apr-Jun;35(2):253-259; 2. Clinical Opiate Withdrawal Scale. https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf. Accessed March 14, 2016.

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WAIVER AND RELEASE OF LIABILITY FORM

IN CONSIDERATION of the risk of injury or overdose while participating in the BUPRENORPHINE / NALOXONE TREATMENT (the "Activity"), and as consideration for the right to participate in the Activity, I hereby, for myself, my heirs, or personal representatives, knowingly and voluntarily enter into this Waiver and Release of Liability and hereby waive any and all rights, insurance claims or causes of action of any kind whatsoever arising out of my participation in the Activity, and do hereby release and forever discharge OSAMA ELSHAZLY, MD, located at 2316 W. 23rd Street, Suite A, Panama City, FL 32405, his affiliates, managers, staff, volunteers, and assigns, for any physical or psychological injury, including but not limited to illness, paralysis, death, damages, economical or emotional loss, that I may suffer as a direct result of my participation in the aforementioned Activity, including traveling to and from an appointment related to this Activity.

I HEREBY ASSUME ALL OF THE COSTS ASSOCIATED WITH PARTICIPATING IN ANY/ALL ACTIVITIES associated with this treatment program, including by way of example and not limitation, any costs that may arise from negligence or carelessness on the part of the persons or entities being released, from any/all insurance claims, or because of possible liability without fault.

I certify that I am physically fit, have sufficiently prepared for participation in this activity, and have not been advised to not participate by a qualified medical professional. I certify that there are no health-related reasons or problems which preclude my participation in this activity.

In consideration of my application and permitting me to participate in this activity, I hereby take action for myself as follows:

(A) I WAIVE, RELEASE, AND DISCHARGE from any and all insurance liability, including but not limited to, liability arising from the negligence or fault of the entities or persons released, for my death, disability, personal injury, property damage, property theft, or actions of any kind which may hereafter occur to me including my traveling to and from this Activity,

(B) INDEMNIFY, HOLD HARMLESS, AND PROMISE NOT TO SUE the entities or persons mentioned in this paragraph from any and all liabilities or insurance claims made as a result of participation in this activity, whether caused by the negligence of release or otherwise.

I hereby consent to receive medical treatment which may be deemed advisable in the event of injury, accident, and/or illness during this activity.

The Waiver and Release of Liability Form shall be construed broadly to provide a release and waiver to the maximum extent permissible under applicable law.

I CERTIFY THAT I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT AND I SIGN IT OF MY OWN FREE WILL.

Participant's Signature	Date	Participant's Name (Please print legibly)	Age

Osama Elshazly, MD
2103 Jenks Ave.
Panama City, FL 32405
(850) 785-0085 office
(850) 785-0558 fax

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT NAME: _____ DOB: _____

ADDRESS: _____ City, State, Zip _____

Receive Records **From** Previous Doctor:

_____
Healthcare Provider / Facility

_____
Address

_____
City, State, Zip

_____
Office phone # / Fax #

Release Records To:

Osama Elshazly, MD

2103 Jinks Ave

Panama City, FL 32405
City, State, Zip

(850) 785-0085 / (850) 785-0558
Phone # / Fax #

Information to be released: One (1) year of Chart Notes, Medical History, Medication List, Psychiatric Care, Psychological Testing, Alcohol / Drug Abuse / Treatment; Two (2) years of Lab reports and Radiology reports.

Purpose of Disclosure:

X Further / Continuing Medical Care ⇛ Legal ⇛ Insurance

⇛ Other

Patient Rights Regarding this Disclosure:

I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present to the office of Osama Elshazly, MD. I understand that revocation will not apply to information that has already been released. I understand that revocation will not apply to my insurance company when the law provides my insurer to a right to contest a claim under my policy. Unless otherwise revoked this authorization will expire one (1) year from the date signed.

_____ _____ _____

Screener and Opioid Assessment for Patients with Pain (SOAPP)® Version 1.0 - 14Q

The Screener and Opioid Assessment for Patients with Pain (SOAPP)® Version 1.0 is a tool for clinicians to help determine how much monitoring a patient on long-term opioid therapy might require. Physicians remain reluctant to prescribe opioid medication because of concerns about addiction, misuse, and other aberrant medication-related behaviors, as well as liability and censure concerns. Despite recent findings suggesting that most patients are able to successfully remain on long-term opioid therapy without significant problems, physicians often express a lack of confidence in their ability to distinguish patients likely to have few problems on long-term opioid therapy from those requiring more monitoring.

SOAPP® version 1.0 is a quick and easy-to-use questionnaire designed to help providers evaluate the patients' relative risk for developing problems when placed on long-term opioid therapy. Version 1.0 -14Q is:

- A brief paper and pencil questionnaire
- Developed based on expert consensus regarding important concepts likely to predict which patients will require more or less monitoring on long-term opioid therapy (content and face valid)
- Preliminary reliability data (coefficient α) from 175 patients chronic pain patients
- Preliminary validity data from 100 patients (predictive validity)
- Simple scoring procedures
- 14 items
- 5 point scale
- <8 minutes to complete
- Ideal for documenting decisions about the level of monitoring planned for a particular patient or justifying referrals to specialty pain clinic.
- The SOAPP® is for clinician use only. The tool is not meant for commercial distribution.
- The SOAPP® is **NOT** a lie detector. Patients determined to misrepresent themselves will still do so. Other clinical information should be used with SOAPP® scores to decide on a particular patient's treatment.
- The SOAPP® is **NOT** intended for all patients. The SOAPP® should be completed by chronic pain patients being considered for opioid therapy.
- It is important to remember that all chronic pain patients deserve treatment of their pain. Providers who are not comfortable treating certain patients should refer those patients to a specialist.

 The SOAPP® was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PainEDU.org

SOAPP® Version 1.0-14Q

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center 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.

Please answer the questions below using the following scale:

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

1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
6. How often have you attended an AA or NA meeting?	0 1 2 3 4
7. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
9. How often have your medications been lost or stolen?	0 1 2 3 4
10. How often have others expressed concern over your use of medication?	0 1 2 3 4

 The SOAPP® was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PainEDU.org

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

11. How often have you felt a craving for medication?	0 1 2 3 4
12. How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
14. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

Scoring Instructions for the SOAPP® Version 1.0-14Q

To score the SOAPP® V.1- 14Q, simply add the ratings of all the questions:

A score of 7 or higher is considered positive.

Sum of Questions	SOAPP® Indication
> or = 7	+
< 7	-

What does the Cutoff Score Mean?

For any screening test, the results depend on what cutoff score is chosen. A score that is good at detecting patients at-risk will necessarily include a number of patients that are not really at risk. A score that is good at identifying those at low risk will, in turn, miss a number of patients at risk. A screening measure like the SOAPP® generally endeavors to minimize the chances of missing high-risk patients. This means that patients who are truly at low risk may still get a score above the cutoff. The table below presents several statistics that describe how effective the SOAPP® is at different cutoff values. These values suggest that the SOAPP® is a sensitive test. This confirms that the SOAPP® is better at identifying who is at high risk than identifying who is at low risk. Clinically, a score of 7 or higher will identify 91% of those who actually turn out to be at high risk. The Negative Predictive Values for a cutoff score of 7 is .90, which means that most people who have a negative SOAPP® are likely at low-risk. Finally, the Positive likelihood ratio suggests that a positive SOAPP® score (at a cutoff of 7) is nearly 3 times (2.94 times) as likely to come from someone who is actually at high risk (note that, of these statistics, the likelihood ratio is least affected by prevalence rates). All this implies that by using a cutoff score of 7 will ensure that the provider is least likely to miss someone who is really at high risk. However, one should remember that a low SOAPP® score suggests the patient is really at low-risk, while a high SOAPP® score will contain a larger percentage of false positives (about 30%), while at the same time retaining a large percentage of true positives. This could be improved, so that a positive score has a lower false positive rate, but only at the risk of missing more of those who actually do show aberrant behavior.

SOAPP® Cutoff Score	Sensitivity	Specificity	Positive Predictive Value	Negative Predictive Value	Positive Likelihood Ratio	Negative Likelihood Ration
Score 7 or above	.91	.69	.71	.90	2.94	.13
Score 8 or above	.86	.73	.75	.86	3.19	.19
Score 9 or above	.77	.80	.77	.80	3.90	.28

 The SOAPP® was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

To whom it may concern,

I am a practicing physician who prescribes pain and psych medication along with my standard of care and rehabilitation protocols. I have chosen to incorporate a Urine and/or Oral Fluid Prescription Medication Monitoring Program into my practice to constitute trust and compliance while prescribing these potentially addictive medications to my patients.

The use of this valuable diagnostic tool helps me to identify if a new or current patient is following my prescription and/or is consuming any other undisclosed and possibly harmful narcotic(s) that may hinder their rehab. Prescription monitoring is therefore useful for the following purposes:

- Influence positive health behaviors after discharge from a hospital or during treatment
- Deplete clinical variance in rehabilitation
- Use as a standard of care when prescribing an opioid
- Decrease hospital visits and re-hospitalization
- Prevent toxicity / overdose
- Identify diversion, abuse and addiction
- Classify risk behaviors (Low, Moderate, High)
- Decrease medical malpractice of wrongful death from overdose in my practice

It is because these prescription narcotics are necessary in treating the chronic pain or depression my patients suffer from that I test for compliance. However, due to the addictive and abusive behavior these drugs can cause, I feel performing random medication testing is a very important procedure when used under the guidelines below.

My UDT (Urine/oral fluid Drug Testing) Protocols for Prescription Management:

- Test upon initial evaluation if the Dx indicates a need to prescribe a pain/psych medication
- Test all patients on a narcotic as I feel medically necessary for compliance, diversion, suspicion of abuse
- Test patients who ask for a specific medication other than what I prescribed them
- Test patients who have had a lapsed time in visiting this practice for treatment
- If a patient tests positive for an undisclosed drug/medication, retest and council them at each visit until I can justify improved compliance
- Test patients who complain of an exacerbation in pain, which might require increase of dosage
- Test newly discharged hospital patients who have been prescribed a narcotic medication
- Test my patient prior to a procedure that requires anesthesia to identify harmful substances
- Utilize an Opioid Treatment Agreement for all patients who present chronic pain and verify they will be coming only to me for treatment and to be prescribed these medications

Laboratory guided prescription monitoring is essential for documentation of compliance. This procedure also serves as an effective measure to identify addictive behaviors and as a deterrent for doctor shoppers and crimes. This procedure is meant to produce the best treatment outcome for my patients and is therefore medically necessary as my standard of care.

Sincerely,

_____

Osama Elshazly, MD
2103 Jenks aVE
Panama City, FL 32405
(850) 785-0085 office - (850) 785-0558 fax

Buprenorphine / Naloxone Treatment Agreement
(Please Read and Initial Each Statement)

Patient Name _____ Date _____

I am requesting that my doctor provide buprenorphine/naloxone treatment for opioid (name of drug) _____ addiction. I freely and voluntarily agree to accept this treatment agreement, as follows:

1. ____ I agree to keep, and be on time to, all my scheduled appointments with the doctor and his/her assistant.
2. ____ I agree to conduct myself in a courteous manner in the physician's clinic.
3. ____ I agree to pay all office fees for this treatment at the time of my visits. I will be given a receipt that I can use to get reimbursement from my insurance company if this treatment is a covered service. I understand that this medication will cost between $5 - $10 per day just the the medication. The office visits are a separate charge.
4. ____ I understand that the use of buprenorphine/naloxone by someone who is addicted to opioids could cause them to experience severe withdrawal.
5. ____ I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the doctor will not see me and I will not be given any medication until my next scheduled appointment.
6. ____ I agree not to sell, share, or give any of my medication to another person. I understand such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal.
7. ____ I agree not to deal, steal, or conduct in any other illegal or disruptive activities in the vicinity of the doctor's office or anywhere else.
8. ____ I agree that my prescription can only be given to me at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.
9. ____ I agree that the medication I receive is my responsibility and that I will keep it in a secure place. I agree that lost medication will not be replaced regardless of the reason for loss.
10. ____ I agree not to obtain medications from any other physician, pharmacist, or other source without informing my treating physician (Dr Elshazly). I understand that mixing buprenorphine/naloxone with other medications, especially benzodiazepines (sedatives or tranquilizers) such as Valium (diazepam), Xanax (alprazolam), Librium (chlordiazepoxide), Ativan (lorazepam), and/or other drugs of abuse including alcohol, can be dangerous. I also understand that a number of deaths have been reported in persons mixing buprenorphine with benzodiazepines. I also understand that I should not drink alcohol while taking this medication as the combination could produce excessive sedation or impaired thinking or other medically dangerous events.

11. ____ I agree to take my medication as the doctor has instructed, and not to alter the way I take my medication without first consulting the doctor.

12. ____ I understand that medication alone is not sufficient treatment for my disease and I agree to participate in the recommended patient education and relapse prevention program, to assist me in my recovery.

13. ____ I understand that my buprenorphine/naloxone treatment may be discontinued and I may be discharged from the clinic if I violate this agreement.

14. ____ I understand that there are alternatives to buprenorphine/naloxone treatment for opioid addiction including:
    a. Medical withdrawal and drug-free treatment
    b. Naltrexone treatment
    c. methadone treatment

    My doctor will discuss these with me and provide a referral if I request this.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date