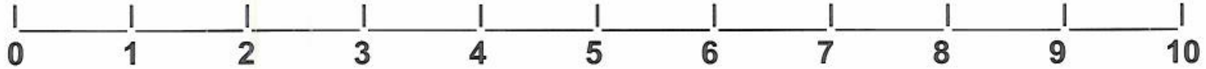
CEDARS-SINAI MEDICAL CENTER®
SPINE CENTER

PAIN DRAWING

PATIENT I.D.

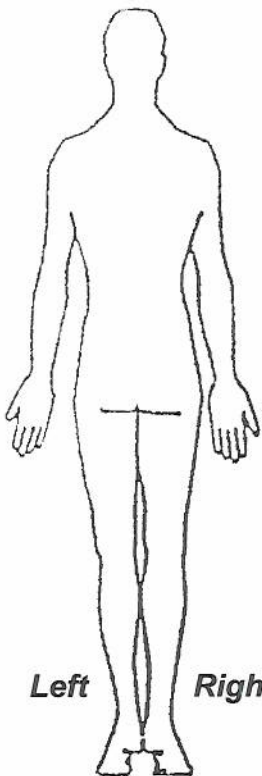
1. How much pain in general can you tolerate?

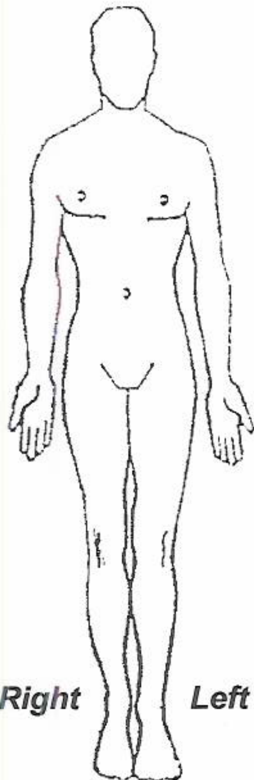


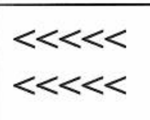
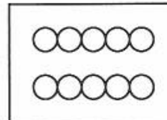
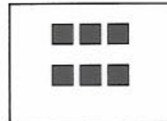
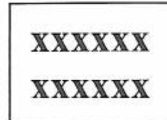
No Pain — Worst pain Imaginable

2. Where is your pain now?

Mark the areas on your body using the appropriate symbols to describe your symptoms.





TYPE OF PAIN	SYMBOL
Ache	
Numbness	
Pins & Needles	
Burning	
Radiating Pain	

3. How bad is your pain?

Neck pain ______ %

Arm pain ______ %

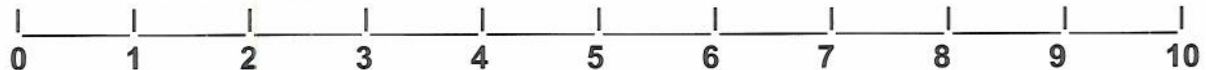
Total 100%

Back pain ______ %

Leg pain ______ %

Total 100%

4. How bad is your pain now?



No Pain — Worst pain Imaginable

5. The duration of pain:

❑ Continuous ❑ Positional ❑ Intermittent (On/Off) ❑ Unable to Rate

6. Have you taken pain medication in the past 24 hours?

❑ YES ❑ NO

Form No. 9402 (Rev. 2/13/09)

CEDARS-SINAI MEDICAL CENTER.
SPINE CENTER

PHYSICIAN INFORMATION

PATIENT I.D.

Please provide your current Physician's information. Write down as much information you can provide (i.e., Name & City), so that we may keep them informed of your progress.

REFERRING PHYSICIAN

Name: ____________________
(Last, First)

Specialty: ____________________

Address: ____________________
(Street)

____
(City, State, Zip Code)

Phone: (______) ____________ Fax: (______) ____________

INTERNIST / PRIMARY CARE PHYSICIAN

Name: ____________________
(Last, First)

Specialty: ____________________

Address: ____________________
(Street)

____
(City, State, Zip Code)

Phone: (______) ____________ Fax: (______) ____________

OTHER PHYSICIAN INVOLVED IN YOUR CARE

Name: ____________________
(Last, First)

Specialty: ____________________

Address: ____________________
(Street)

____
(City, State, Zip Code)

Phone: (______) ____________ Fax: (______) ____________

WORKMANS COMPENSATION *(IF APPLIES)*

Name: ____________________
(Last, First)

Specialty: ____________________

Address: ____________________
(Street)

____
(City, State, Zip Code)

Phone: (______) ____________ Fax: (______) ____________

CEDARS-SINAI®

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Failure to provide all information may invalidate this authorization

Authorization for: Copies of Medical Record ❑ Paper ❑ Electronic ❑ Other
❑ Inspect or Review Medical Record

Patient Information	Patient Name: ____________________ MRN: __________ (Last Name) (First Name) Date of Birth: ____________________ Phone: __________ Address: ____________________ City: __________ State: __________ Zip: __________

Release To Request From	**I authorize Cedars-Sinai to Release / Request Medical Records** **Release To:** ❑ **Request From:** ❑ Person / Organization: ____________________ Address: ____________________ City / State / Zip: ____________________ Phone: __________ Fax: __________	**Purpose**	**For the following:** ___ Continuing Care ___ Insurance ___ Legal ___ Personal Use ___ Other: __________ __________
Information to Release	Treatment Dates: ____________________ ___ Discharge Summary ___ Emergency Record ___ Operative Report ___ Billing Record ___ Laboratory Report ___ EKG ___ Pathology Report ___ Radiology Report ___ Consultation Report ___ Xray Film / Images CD ___ Other (*Please Specify*) ____________________ ___ Outpatient / Clinic Record - Clinic / Provider Name: ____________________ **State / Federal Laws require specific authorization to release the following types of information:** ___ Mental Health ___ HIV test results ___ Alcohol / Drug Abuse A separate authorization is required for psychotherapy notes.	**Fees**	**Based on California Evidence Code Sections 1560-1567 Fees may be charged for medical record copies.**

Health Information Management Department
8700 Beverly Blvd., Room 2901, Los Angeles, CA 90048
Email: GroupHIDInternetInquiries@cshs.org
Fax: 310-423-0113

Form No. 2034 (Rev. 8/15/13) Front

Section	Content
Delivery Instructions	❑ Mail records directly to person or organization specified ❑ Call Requestor when records are ready for pick up I authorize ____________________ to pick up my medical record copies. Relationship to patient: ____________________ ❑ E-mail: ____________________ ❑ Other: ____________________
Notice of Rights	I understand that: 1. If I refuse to sign this authorization my refusal will not affect my ability to obtain treatment. 2. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. 3. I may revoke this authorization at any time in writing, signed by me or on my behalf and delivered to **Cedars-Sinai Medical Center, Health Information Department, 8700 Beverly Blvd., Room 2901, Los Angeles, CA 90048.** 4. If I revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving the revocation. 5. I have a right to receive a copy of this authorization. 6. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law. 7. If this ❑ is checked, the Requestor will receive compensation for the use or disclosure of my information.
Expiration	Without my written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified: ____________________
Signature	Signature: ____________________ *(Patient or Legal Representative)* Date: ____________________ Legal Representative Relationship: ____________________

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