

Diagnostic Block Evaluation Sheet

Patient Name:
 Dob:
 Hospital:

Attach Label

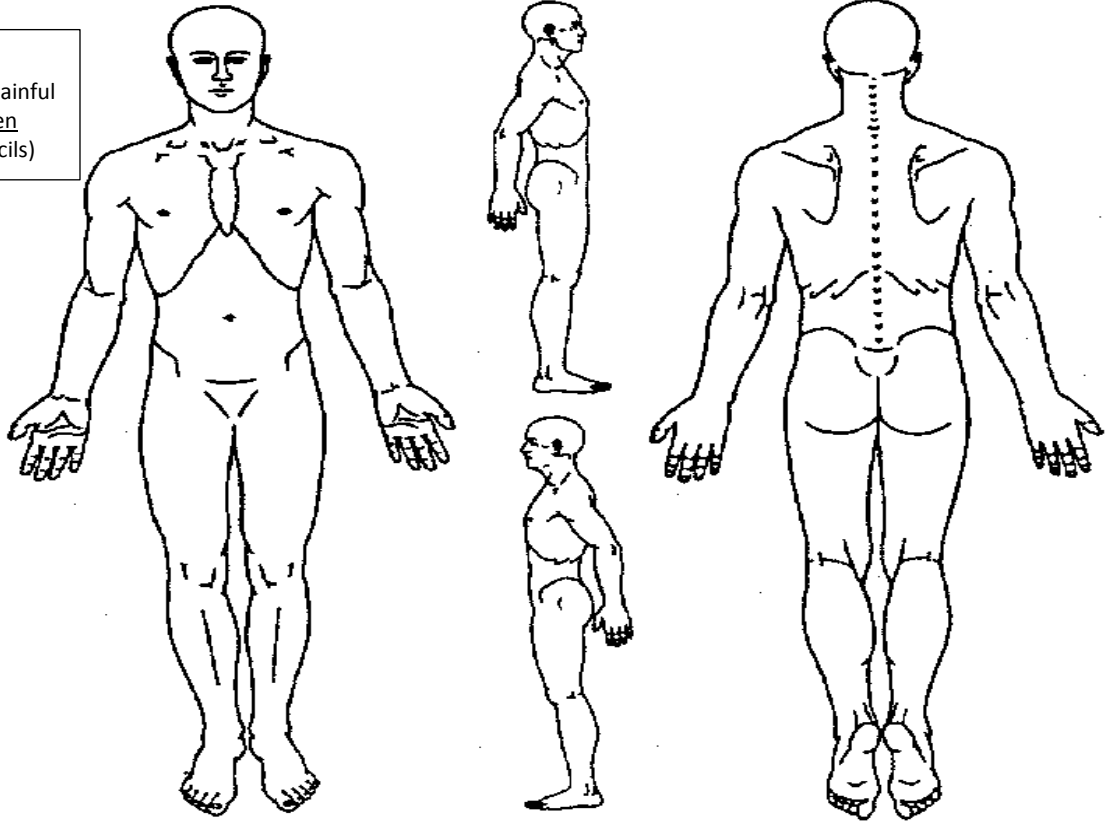
Procedure:

Doctor:

Date:

Pain Map:

Please shade painful areas with a pen
 (don't use pencils)



Four Activities Limited by Target Pain:

- 1:
- 2:
- 3:
- 4:

Worst pain ever experienced /10
 Worst ever target/index pain /10
 Target/Index pain today: /10

Descriptions:

Target Pain:

Other Pains:

.....

Patient Remarks:

Much worse – Worse – Same – Better – Much Better
 Activities Restored: 1 - 2 - 3 - 4
 Comments:

Hospital Nurse Remarks:

Signature:

Instructions: Please fax, email, post or deliver the completed form to Frankston Pain Management within 3 days of the procedure. A review appointment will be given after the form has been checked by your doctor

10								
9								
8								
7								
6								
5								
4								
3								
2								
1								
0								
NRS	Pre	Post	30min	60min	90min	2h	3h	4h

Please mark 0-10 pain score with a X at the relevant time post block

Interpretation and Action Plan:

Signed: Doctor & Date

Frankston Pain Management

Interventional and Interdisciplinary Pain Management

“Maximising Function, Minimising Pain and Suffering”

7/20 Clarendon St,
Frankston, Vic, 3199
Tel: 03 9770 0522

Email: info@fpmx.com.au
Web site: www.fpmx.com.au
Fax: 03 9770 0944

Patient Name:

Date:

Procedure:

Before			Day 2		
5 mins			Day 3		
30 mins			Day 4		
60 mins			Day 5		
90 mins			Day 6		
2 hours			Day 7		
3 hours			Day 8		
4 hours			Day 9		
5 hours			Day 10		
6 hours			Day 11		
7 hours			Day 12		
8 hours			Day 13		
			Day 14		

Was the procedure helpful (circle response) YES / NO

How Helpful? (circle response)

Nil 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Comments: