Patient Name

DOB:

MR #

UW Health
(University of Wisconsin Hospitals and Clinics Authority)
RADIOLOGY POST INJECTION PAIN ASSESSMENT – NON-STEROID

Date: _____

During business hours call (608) 263-9729 After hours call (608) 262-2122 and ask for the bone radiologist on call

Name of Procedure: _____ Radiologist: _____/_____

Ordering Physician: _____ Medication Used: _____ /cc _____

Please **circle** the number which best describes your pain in the table below.

PAIN RECORD

Circle *the number* that best describes your pain **PRIOR** to your procedure:

	No Pain Imaginable									Worst Pain
Pre-Injection Pain:	0	1	2	3	4	5	6	7	8	9	10

Circle *the number* that best describes your pain **AFTER** your procedure:

	No Pain Imaginable									Worst Pain
Immediate Post-Injection Pain:	0	1	2	3	4	5	6	7	8	9	10

DATE	**TIME**	**POST INJECTION PAIN ASSESSMENT**										
		No Pain									Worst Pain Imaginable	
Day of Injection	Evening	0	1	2	3	4	5	6	7	8	9	10
Next Day	Morning	0	1	2	3	4	5	6	7	8	9	10
	Evening	0	1	2	3	4	5	6	7	8	9	10
Second Day	Morning	0	1	2	3	4	5	6	7	8	9	10
	Evening	0	1	2	3	4	5	6	7	8	9	10

Please note any side-effects, problems, or comments: _____

_____

_____

_____

_____

After you have completed this questionnaire, please return the form in the envelope provided.

IF RECEIVED RETURN TO:
UW Health at The American Center
4602 Eastpark Blvd, Room 1053, Mail Code AC03
Madison, WI 53718-2002