

SECTION 5:  
**COORDINATION OF CHRONIC PAIN  
AND MENTAL HEALTH TREATMENT**

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*Mind and Body*

- Living with chronic pain can cause or exacerbate symptoms of anxiety and depression, even in patients without a history of mental health problems. Mental health screening and support is crucial in dealing with chronic pain issues.
- Many mental illnesses, such as anxiety or bipolar disorders, are characterized by poor stress tolerance, and consequently poor pain tolerance. Some patients may perseverate on their pain. Encourage the patient to explore self-management strategies to improve functional outcomes and reinforce functional improvements as a sign of progress.
- Thought disorders (schizophrenia, schizoaffective disorder) may interfere with memory and communication of patterns/intensity of pain and of problems in functioning. Enlist the help of family, friends, case managers, caregivers, or others close to the patient to provide additional information on functioning, non-verbal communication of pain, and behavior.
- Screen for substance abuse. There is a high frequency of substance abuse co-occurring with mental health disorders.

*Care Coordination Between Treating Providers*

- Ask the patient to sign release of information (ROI) authorizations allowing you to share information with the mental health provider.
  - To comply with HIPAA requirements, it is recommended that two separate releases be used – one allowing you to send information to the mental health provider and a second release allowing the mental health provider to send information to you. Having the forms filled out and signed at the same time can emphasize the two-way communication needed to coordinate care. (See sample HIPAA compliant ROI form below.)

## PART I: PRINCIPLES OF PRESCRIBING OPIOIDS

### *Section 5: Coordination of Chronic Pain and Mental Health Treatment*

- Primary care providers should know all medications prescribed to the patient. Coordination of care with the mental health prescriber is particularly important when the patient is on combinations of minor and major tranquilizers or has a very complex medication regimen.
- Some mental health providers do urine drug screens. Informing them of opiate prescriptions will help them interpret any positive results.
- To coordinate care with the mental health provider, contact the Program Director or Clinical Supervisor of the Mental Health Organization (MHO) listed on the Oregon Health Plan Eligibility Card, or call CareOregon for assistance at 503-416-4100 or 1-800-224-4840 outside the Portland metro area.

## ***Authorization for Use or Disclosure of Health Information***

Member name: \_\_\_\_\_ ID #: \_\_\_\_\_

I give permission for \_\_\_\_\_ to use the health information listed below or give a copy to: \_\_\_\_\_

The reason for using this information or giving it out is: \_\_\_\_\_

### **Information that I give permission to be used or given out:**

The entire record     Only those things initialed below:

Dates of service: \_\_\_\_\_

(Please initial the information that can be used or given out)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Drug/alcohol treatment  | <input type="checkbox"/> Psychiatric and mental illness treatment        | <input type="checkbox"/> Problem list           |
| <input type="checkbox"/> Medication list         | <input type="checkbox"/> List of allergies                               | <input type="checkbox"/> Immunization records   |
| <input type="checkbox"/> History and physical    | <input type="checkbox"/> Operative report                                | <input type="checkbox"/> Discharge summary      |
| <input type="checkbox"/> Pathology report        | <input type="checkbox"/> Visit/encounter notes                           | <input type="checkbox"/> Laboratory results     |
| <input type="checkbox"/> X-Ray report            | <input type="checkbox"/> Emergency room record                           | <input type="checkbox"/> EKG report             |
| <input type="checkbox"/> Billing records         | <input type="checkbox"/> Human Immunodeficiency Virus (HIV) test results | <input type="checkbox"/> Health plan records    |
| <input type="checkbox"/> Genetic testing records | <input type="checkbox"/> Dental records                                  | <input type="checkbox"/> Physical therapy notes |
| <input type="checkbox"/> Other: _____            |  |   |

I understand that I can ask someone to help me understand how this form will be used.

I understand that if the person or organization designated above is not a health care provider or health plan covered by federal privacy laws, the information listed above could be given out by them, and will no longer be protected by those regulations.

I understand that I may look at or ask for copies of any information that will be given out because of this authorization.

I understand that I may refuse to sign this form, and that I do not need to sign it to receive healthcare, or to determine eligibility for benefits, or in order for payment for healthcare to be made.

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I understand that I may change my mind and decide to cancel my permission at any time. I understand that in order to cancel my permission, I must provide a written, signed, and dated statement indicating that to the person or organization shown above. I also understand that if I cancel this authorization, the information may have already been used or given out before I changed my mind. Unless I change my mind about giving my permission, before 365 days from now, this authorization will stop 365 days from the date that I signed this form, or on a different date that I choose.

- I ask for a different expiration date of: \_\_\_ / \_\_\_ / \_\_\_
- Other event that would signal the expiration of this authorization: \_\_\_\_\_  
\_\_\_\_\_

I understand that I may have a copy of this form for my records after it is signed.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed name of member  
or member's legal representative \_\_\_\_\_

Relationship to the member \_\_\_\_\_

Signature of witness \_\_\_\_\_ Date \_\_\_\_\_

Printed name of witness \_\_\_\_\_