IFN RAMP Recovery And Monitoring Program

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24/7 Crisis Hotline: 800-662-0108
www.NJSNA.org

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RAMP Director

Pain Management Evaluation Form

(To be filled out by Pain Specialist)

Participant: _____ Participant #: _____

Report: Month: _____ Year: _____

Please check the appropriate finding for each listed criteria: (S = Satisfactory; U = Unsatisfactory)	S	U
1. Attends sessions regularly.	____	____
2. Actively participates in session.	____	____
3. Shares experiences and feelings freely.	____	____
4. Appears actively involved in own recovery process.	____	____

Please check the answer to each of the following questions: (Y = Yes; N = No)	Y	N
5. Does the participant appear compliant with RAMP contract?	____	____
6. Is the participant able to practice their profession safely and competently while under the influence of their pain medication for chronic pain condition(s)?	____	____

Please explain any unsatisfactory or "No" response.

_____

_____

_____

Medications:

_____

_____

_____

_____ _____

Physician's Signature Date

_____ _____

Physician's Name (Printed) Phone Number

I verify that _____ has attended pain management session on the following date _____.