

**The Emergency Department Guide to Distinguishing the
Legitimate Headache Sufferer from the
Drug Seeking Patient**

Patient keys to drug abuse:

1. Patient makes frequent visits to the Emergency Room.
2. Patient states multiple allergies to non-narcotic interventions.
3. Patient has extensive knowledge of drug action.
4. Patient requests specific medications and dosage.
5. Patient has multiple prescriptions for analgesic medications.
6. Patient requests large number of pills and prescription refills.
7. Patient has unusual, irrational stories.
8. Patient's pain level is inconsistent with drug requirement.
9. Patient has multiple doctors and/or multiple treatment sites.
10. Patient is using increased amount of alcohol.
11. Patient does not make provision for follow-up care.
12. Patient's symptoms do not fit a diagnostic pattern of headache.

Factors confirming patient legitimacy:

1. Patient has doctor who can confirm diagnosis and give reliable patient information.
2. Patient's medical history is consistent with diagnosis of headache.
3. Patient has had prior diagnostic work-up.
4. Patient is non-demanding regarding medication necessities.
5. Patient is deemed reliable by Emergency Staff.

Other factors which may be characteristic of patient with confirmed headache diagnosis:

1. Patient may experience depression.
2. Patient may exhibit feelings of low self-esteem.
3. Patient may indicate feelings of frustration at home or on the job.
4. Patient may reduce social/work activities.
5. Patient may feel loss of control over situation.
6. Patient feels headache encompasses entire life.
7. Patient exhibits hostilities over physician's inability to control or alleviate headache.

Physician Provided Emergency Room Treatment Form

This form is being provided to assist you in treating my patient who is a diagnosed migraine sufferer. My patient sometimes experiences migraine so severe he/she requires emergency treatment. Migraine is a chronic, recurring neurological disease which is treatable. My patient is not a "drug seeker" or substance abuser. My patient uses the prescription(s) listed below to provide abortive and/or preventive treatment for migraine. Unfortunately, some migraine episodes may require treatment beyond the current prescribed regimen. My patient may need pain relief medications to treat this episode.

Patient Diagnosis and Treatment Information

Patient Name _____ Date of Birth _____

Date of Diagnosis _____ Date of Last Visit _____

Current migraine abortive medication(s) _____

Current migraine prevention medication(s) _____

Other pain medication(s) _____

Prescription(s) proven ineffective for my patient's migraine treatment _____

Medication allergies _____

For my patient's emergency treatment, I suggest the following medication(s): _____

Thank you for reviewing this important information and treating my patient. My patient has a legitimate migraine condition and is not visiting the emergency room to obtain narcotics or other medications under false pretenses.

Signature _____
Date _____

Office Phone _____
Office Address _____

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Emergency Room Treatment Form

I am experiencing a severe migraine headache attack. I am not a substance abuser or "drug seeker." Below, I have provided information about my current migraine episode, my current and prescribed treatments and my medical insurance information. My physician also filled out a form verifying my diagnosis and outlining my treatment(s).

Patient Information

Name _____ Date of Birth _____
 Address _____
 City _____ State _____ Zip _____
 Home phone _____ Office Phone _____
 Insurance carrier _____
 Insurance policy number _____
 Other info _____
 Employer _____
 Emergency contact _____
 Relationship _____ Phone _____

Patient Treatment Information

I am experiencing the following symptoms (circle those that apply):

Extreme head pain Nausea Light sensitivity Sound sensitivity

Others _____

On a scale of 1-10, I currently rate my pain at _____.

I have taken the following medication(s) for my current migraine attack:

Medication	Dose	Time taken
Medication	Dose	Time taken
Medication	Dose	Time taken

Other Patient Information

Other non-migraine medications _____

Supplements or vitamins _____

Over-the-counter medications _____

Medication allergies _____

Other medical conditions _____

Signature _____ Date _____

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