Safe Pain Control Patient Evaluation

This form is to be completed by your child's primary caretaker.
What you say matters—help us make these materials even better.

Visit *facs.org/**safepaincontrol*** to complete the survey online.

1 BEFORE YOUR OPERATION

Did you receive the American College of Surgeons patient education brochure on Safe and Effective Pain Control after Surgery? ◯ **Yes** ◯ **No**

Rate how well you were prepared or informed about the following before your child's operation:

	Very Well	Well	Fairly	Poorly	Not Informed
Your child's pain control options	◯	◯	◯	◯	◯
When to give pain medication	◯	◯	◯	◯	◯
Alternatives to opioids whenever possible	◯	◯	◯	◯	◯
Using the lowest dose of opioids for the shortest amount of time	◯	◯	◯	◯	◯
Reducing your child's chances of becoming addicted to opioids	◯	◯	◯	◯	◯
Recognizing the signs of opioid overdose	◯	◯	◯	◯	◯
Opioid storage and disposal options	◯	◯	◯	◯	◯

How severe was your child's pain before his or her operation?

- ◯ **Severe (can't do anything, not even sleep or rest)**
- ◯ **Moderate (trouble moving around due to pain)**
- ◯ **No pain/only a little pain**

Was your child taking pain control medications before surgery? ◯ **Yes** ◯ **No**

If yes, was a pain plan developed specifically for your child? ◯ **Yes** ◯ **No**

What did your child use to manage his or her pain? Please check all that apply:

- ☐ **Acetaminophen (Children's Tylenol®)**
- ☐ **NSAIDs (anti-inflammatories):** ____________________
- ☐ **Opioids:** ____________________
- ☐ **Other (please describe):** ____________________

____

2 AT HOME

What operation did your child have? ____________________

How long was your child in the hospital? ◯ Less than 24 hours ◯ 1 to 3 days ◯ 4 to 5 days ◯ More than 5 days

How much did pain **interfere or prevent** your child from performing the following during the first 4 days at home?

	0	1	2	3	4	5	6	7	8	9	10
Doing activities in bed (sitting up, turning, repositioning)											
Doing activities out of bed (walking, sitting in a chair, playing normally)											
Falling asleep											
Staying asleep											

Please rate the severity of your child's pain at home. Check the number that best describes his or her pain.

	0	1	2	3	4	5	6	7	8	9	10
Day 1											
Day 4											

Evaluation continued on back →

Parents and patients: We want to hear from you.

Please complete and return this form to help improve our pain control programs.

2 AT HOME—FIRST 4 DAYS (continued)

How much distress and bother did your child have at home?

	None at all 0	1	2	3	Very much 4
Nausea					
Constipation					
Drowsiness					
Itching					
Vomiting					
Dizziness					
Depression					

What did you use to manage your child's pain? Please check all that apply:

- ☐ **Non-medication therapies**
- ☐ **Acetaminophen (Children's Tylenol®, Tempra®, Panadol®, Aspirin-free Paracetamol®, FeverAll®)**
- ☐ **NSAIDs (anti-inflammatories):** Ibuprofen (Advil®, Motrin®)
- ☐ **Opioids**
  - ☐ Hydrocodone (Norco®, Vicodin®, Lorcet®)
  - ☐ Hydromorphone (Dilaudid®)
  - ☐ Oxycodone (OxyContin®)
  - ☐ Oxycodone with acetaminophen (Percocet®, Endocet®)
- ☐ **Other** (please describe): ____________

3 PRESCRIBED OPIOIDS

Was your child given a prescription for opioids? .... ◯ **Yes** ◯ **No**

Was the prescription filled? .... ◯ **Yes** ◯ **No**

Did your child need a refill? .... ◯ **Yes** ◯ **No**

When your child stopped feeling pain, did you safely dispose of the opioids? .... ◯ **Yes** ◯ **No**

Did you give your child opioids while at home? ◯ **Yes** ◯ **No**

If yes, please answer the following questions:

How many opioid pills or milliliters of opioids was your child prescribed? ____________

How many days was your child told to take opioids (e.g., 5 days, 7 days, 1 month)? ____________

How many pills or milliliters of opioids were left? ____________

4 ABOUT YOU AND YOUR CHILD

Is your child male or female? ◯ **Male** ◯ **Female**

What is your child's predominant ethnicity?

◯ **White, Non-Hispanic** ◯ **Black, Non-Hispanic**
◯ **Hispanic** ◯ **Asian/Pacific Islander**
◯ **American Indian/ Alaskan Native** ◯ **Other:** ____________

Is English the primary language spoken in your home?

◯ **Yes** ◯ **No**

What the highest grade level completed by your child's caretakers?

◯ **8th grade or less** ◯ **Some high school/no diploma**
◯ **High school graduate or GED** ◯ **Some college or 2-year degree**
◯ **4-year college degree or higher**

Do you normally need assistance completing medical forms?

◯ **Yes** ◯ **No**

Who is assisting with your child's care?

◯ **I am providing care alone** ◯ **My spouse/partner**
◯ **Friend/relative** ◯ **Home health care nurse**

Please complete the following table:

	Strongly Agree	Agree	Disagree	Strongly Disagree
I was satisfied with the information we received on pain control	◯	◯	◯	◯
I felt prepared for my child's operation	◯	◯	◯	◯
I felt prepared for my child's home care	◯	◯	◯	◯
I was satisfied with the overall quality of my child's care.	◯	◯	◯	◯

Comments:

Thank you for completing this survey. This information is used only by the American College of Surgeons to help us improve the care provided to future surgical patients. The answers you provided are confidential and will be used only by the Division of Education to improve patient care.

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