HEALTHY LIVING PRIMARY CARE

INFORMED CONSENT FOR OPIOID TREATMENT

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician/health care provider comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

I have agreed to use opioids (morphine-like drugs) as part of my treatment for pain. I understand that these drugs have no evidence to treat chronic pain and have a high potential for misuse and are therefore closely controlled by the local, state, and federal government. Because my physician/ health care provider is prescribing such medication to help manage my pain, I agree to the following conditions:

_____ I have read "What You need to Know about Opioids" and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction.

_____ It is **unrealistic to expect opioids to relieve all discomfort**. We hope to **reduce your pain** so that you can **regain function**; that is to allow you to enjoy activities that you participated in prior to the onset of your pain. We will continue to ask that you participate in activities that improve your ability to perform daily activities. We may, during your treatment, ask you to exercise, attend classes, or see a specialist of our choosing.

_____ I am responsible for my pain medications. I agree to take the medication only as prescribed.

- I understand that increasing my dose without the close supervision of my physician could lead to drug overdose.
- I understand that decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal.

_____ I will not request or accept controlled substance medication from any other physician (including emergency room or urgent care physicians) while I am receiving such medication from my physician/health care provider.

_____ It is my responsibility to notify my physician/health care provider of any side effects. I am also responsible for notifying my physician immediately if I need to visit another physician or need to visit an emergency room due to pain, or if I become pregnant.

_____ To the best of my ability, I will communicate fully with my physician at the initial and all follow-up visits regarding my pain level and functional activity along with any side effects of the medications. This information allows my physician to adjust my treatment plan accordingly.

_____ I am responsible for my opioid prescriptions. I understand that:

- Medication name and dosage and direction: _____
- Number of pills per month: _____ Frequency of appointment: every _____months
- Refill prescriptions can be written for a maximum of one-month supply and will be filled at the **same pharmacy:** _____ Address: _____
- It is my responsibility to schedule appointments for the next opioid refill before I leave the clinic or within 3 days of the last clinic visit.
- It is the patient's responsibility to keep track of the amount of medication remaining and to schedule

appointments appropriately.

- I will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment.
- Refills will **NOT** be made if I "run out early" or "lose a prescription" or "spill or misplace my medication" or for any other reason. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
- Refills will **NOT** be made as an "emergency" such as a Friday afternoon because I "Suddenly realized I will run out tomorrow." I will call at least seventy-two (72) hours ahead if I need assistance with a controlled substance medication prescription.
- Refills of opioid medications will be made **ONLY** during **regular business hours**. Monday through Friday, **in person, once each month during a scheduled office visit**. Refills will **NOT** be made at night, on holidays, weekends, via phone or email.
- If I am unable to obtain my prescriptions monthly, I will be responsible for finding a local physician who can take over the writing of my prescriptions, but you need to notify our office ahead of time.
- Prescriptions will not be written in advance due to vacations, meetings, or other commitments.
- If an appointment for a prescription refill is *missed*, another appointment will be made as soon as possible. *Immediate* or *emergency* appointments will not be granted.
- No "walk-in" appointments for opioid refills will be granted.
- I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. I will then report the stolen medication to my physician. If my medications are lost, misplaced, or stolen, my physician may choose not to replace the medications or to taper and discontinue the medications.
- **You must bring back all opioid medications and adjunctive medications prescribed by your physician in the original containers/bottles at every visit.**

_____ **Should your prescription need to be changed to another medication prior to your "due date", all unused medication must be brought to our office prior to receiving a new prescription.**

_____ If it appears to the physician/health care provider that there is no improvement in my daily function or quality of life from the opioid substance, it may be discontinued. I will gradually taper my medication as prescribed by the physician.

_____ If drug dependence, tolerance or addiction occurs, I agree to accept **full responsibility** for the risks taken secondary to my consent of opioid consumption for the management of my pain. Signs of addiction, abuse, or misuse shall prompt the need for substance dependence treatment as well as weaning and detoxification from the opioids.

_____ If I have a history of alcohol or drug misuse/addiction, I must notify the physician of such history since the treatment with opioids for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery is a necessity.

_____ The use of **alcohol**, **benzodiazepines** (i.e. Valium, Ativan, Xanax, clonazepam), other **sedatives**, **marijuana/cannabis/CBD, cocaine**, and other **illicit drugs** together with opioid medications **increases risk of overdose and death.**

_____ You should **NOT** use any illicit substances, such as **cocaine, heroin, marijuana/cannabis/CBD and others,** while taking these medications. This would result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship.

_____ I agree and understand that my physician reserves the right to perform **random or unannounced** urine drug testing. If requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my doctor may change my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the doctor/patient relationship. The **presence of a non-prescribed drug (s) or illicit drug (s)** in the urine will be grounds for termination of the doctor/patient relationship. Urine drug testing is not forensic testing but is done for my benefit as a diagnostic tool and in accordance with legal and regulatory materials on the use of controlled substances to treat pain.

_____ Evidence of **medication hoarding**, **increasing use of medication** without communication to the pain clinic staff, **hostile behavior towards our staff**, **refilling your prescriptions too frequently**, **getting the medication from multiple physicians or pharmacies**, **increasing amounts of medications**, **medication sales**, **unapproved use of other drugs** (alcohol, sedatives or street or "illicit" drugs) during opioid analgesic treatment or other unacceptable behavior will result in the termination of the use of opioid medications.

_____ I understand that the opioid medication is strictly for my own use. The opioid should **never** be given or sold to others because it may endanger that person's health and is **against the law.**

_____ I agree to allow my physician/health care provider to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions *if the physician feels it is necessary*.

_____ I agree to a family conference or a conference with a close friend or significant other *if the physician feels it is necessary*.

_____ I understand that non-compliance with the above conditions will result in a re-evaluation of my treatment plan and discontinuation of opioid therapy. I will be gradually taken off these medications or discharged from the clinic and be provided with information for an addiction specialist. If I violate the pain contract, I will not be given any kind of opioid in the future, even for acute pain from our practice in the future.

I, _____ have read the above information or it has been read to me and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy & acknowledge receipt of this document.

_____

Patient's Name (printed) Signature: Date:

_____

Provider's Name Signature: Date:

Witness's Name Signature: Date: