APC AMERICAN PAIN CONSORTIUM
Center For Pain | Integrated Pain Solutions | Spine Care Specialists
Together With American Pain Consortium

OPIOID (NARCOTIC) AND CONTROLLED SUBSTANCES CONSENT FORM & MANAGEMENT

This agreement between the undersigned (patient) and the providers at the Center for Pain Management is to establish clear conditions for the prescription and use of controlled substances and pain medications prescribed by the provider for the patient. As described below, the management of pain through opioid medications involves risks; the rules contained in this agreement are intended to minimize the risk of adverse outcomes while not impeding your access to appropriate emergency or acute care. Provider and patient agree that this agreement is an essential factor in maintaining the trust and confidence necessary in a provider-patient relationship. The patient agrees to and accepts the following conditions for the management of pain medications prescribed by the provider for the patient:

1. Opioid medications may be prescribed for me ONLY by a physician, nurse practitioner, or physician's assistant at Center for Pain Management.
2. I will not solicit nor accept prescriptions for opioid medications from any other provider without the prior consent of one of the above staff. Specifically, I will notify my provider in advance of any planned upcoming dental or medical procedure that might require pain medications. Also, in the event I require emergency care that includes pain medications, I will inform my provider within one business day, and request the ED records be released to this office.
3. I will only take the currently prescribed medications and only at the dose and frequency prescribed. I will tell my provider if I am using less medication than prescribed. I agree to dispose of any medication appropriately that I have been instructed to stop taking.
4. I will not, under any circumstance, increase my dose or frequency without my provider's permission.
5. I will and do consent to random drug testing and random pill counts at the provider's request. If I fail to provide the sample or present for a pill count when asked or if the results are unsatisfactory, I may forfeit the right to continue receiving medication.
6. I will not use any illegal substances, including marijuana, cocaine, methamphetamine, etc.
7. I will not use this medication with any alcohol-containing beverages.
8. I will not take any prescription or nonprescription sleep aid without first discussing it with my provider and obtaining my provider's permission, including Klonopin, Xanax, Valium, or Ativan.
9. I will not share, sell, or trade my medication for money, goods, or services.
10. I will not undergo any pain management procedures or injections without the preceding consent of any of the above treating providers. Patients are free to transfer their interventional care at any time; we would expect those physicians to assume continued prescribing of all controlled substances.
11. I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my medication for a period of time, and this may precipitate a re-evaluation of my competence to continue on these medications.
12. I understand that an important part of my pain management program may include procedural and other non-drug treatment. It is the intention of the treating provider and me that the chronic

OPIOID (NARCOTIC) AND CONTROLLED SUBSTANCES CONSENT FORM & MANAGEMENT

opioid therapy I am currently on will be titrated to the lowest effectual dose with an eventual expectation of weaning and discontinuation of opioids when they become ineffectual, the risks outweigh the benefits, or they become unnecessary. If I fail to follow-through with my provider's treatment program, I understand and agree that opioids may be weaned and discontinued. Adjuvant medications, such as NSAID's, anti-inflammatories, muscle relaxants, anticonvulsants, and antidepressant medications may continue to be prescribed.

13. I understand that reduction in the intensity of my pain as well as improvement in my quality of life and functional abilities are the desired goals of treatment. Should it become evident to my provider that these objectives are not being met with the use of opioids, I agree to weaning and discontinuation of narcotic medication. I further understand that as the regulatory and consensus opinions regarding what is considered to be a "safe dose" of opioid prescribed is reduced, my dose may be further titrated accordingly; even if it negatively affects my perceived level of pain control. I understand that certain antibiotics/antifungals can affect the metabolism of my medications. I will discuss these issues with my pharmacist. My provider may need to reduce my dosage accordingly.

I understand that the long-term advantages and disadvantages of chronic opioid therapy have yet to be scientifically determined and that opioid treatment may change throughout my time as a patient. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances, in addition to the obvious risks of tolerance, dependence, drug overdose, and death. **These risks increase with increased dosage especially over 40 MMEQ per day, and with the combination of opioids with benzodiazepine medications including Xanax, Alprazolam, Valium, Diazepam, Klonopin, and Clonazepam; opioids with certain other medications, and opioids with alcohol.** My provider will advise me as knowledge and training advance and will make appropriate treatment changes.

I understand that all medications have potential side effects. I understand that the risks of opioid medications increase with increased dosage. I have been fully informed by the provider of the potential side effects including, but not limited to: physical dependence, pseudo-addiction, chemical dependence, addiction, constipation which may be severe enough to require medical treatment, difficulty with urination, drowsiness, cognitive impairment, nausea, itching, depressed respiration, reduced sexual function, adverse effects or injury to organs, and death. A distinct clinical syndrome, "Hyperalgesia Syndrome", has been described in the literature and can result in increased pain from continual and escalated doses of opioid medication. If I take more medication than prescribed, a dangerous situation could result such as coma, organ damage, or even my death.

I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment in my ability to safely perform any activity, I agree not to attempt to perform such activity until my abilities have been properly evaluated and/or my medications have been held for four days.

I agree to waive any applicable privileges or right of privacy or confidentiality with respect to prescription medication and I authorize one of the above staff and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency including the board of pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I understand that my physician or provider will utilize the INSPECT/OARRS website to further assess my compliance.

Patient Name:_____ DOB: _____

OPIOID (NARCOTIC) AND CONTROLLED SUBSTANCES CONSENT FORM & MANAGEMENT

I agree to the following regarding prescription refills: prescription refills of my medication will be made only during regular office hours, in person, once every month during a scheduled office visit, or more frequently as recommended by my doctor and/or provider. Refills will not be made on an emergency basis, nights, weekends, or holidays. I am free to visit an ER or other physician and have them contact my doctor in any emergency situation.

I agree to be evaluated by a psychologist and/or addiction specialist at any time during my treatment at my provider's request. If, in their opinion, I am not a candidate for further narcotic treatment, I agree to weaning and treatment discontinuation.

I understand narcotic medications can slow down my breathing with possible serious life threatening effects, including death. If I am concerned about this possibility, I am aware Narcan (Naloxone), a medication to temporarily reverse the slowed breathing, is available to me as a prescription from my provider, or can be obtained from the pharmacy without a prescription.

1. (Females only): Narcotics are felt to have minimal risk for development of birth defects. However, if I continue to take these medications throughout pregnancy, my child will be born drug-dependent and need specialized care.* I therefore agree that if I plan to become pregnant, or believe I have become pregnant while on these medications, I will immediately notify my obstetrician and Opioid medications may be prescribed for me ONLY by a physician, nurse practitioner, or physician's assistant at Center for Pain Management. I understand that if I continue to take opioid medications during my pregnancy, my baby will be at risk for opioid dependency and neonatal abstinence syndrome.

Provider and patient agree that this agreement is essential to the provider's ability to treat the patient's pain effectively and that failure of the patient to abide by the terms of this agreement may result in the withdrawal of all prescribed medication by the provider and the termination of the provider-patient relationship.

Examples of opioid medication include, but are not limited to: Lortab, Fentanyl, Opana, Vicodin, Norco, OxyContin, MS Contin, Percocet, Kadian, Avinza, Tylox, Methadone, Demerol, Dilaudid, Belbuca, Buprenorphine, Xtampza, Codeine, Subutex, and Suboxone. It is my responsibility to know these and other medications that are opioid compounds that I may be taking.

Acknowledgement

I have read or have had the above form read to me and understand all of it. I have had a chance to have all my questions answered to my satisfaction. By signing this form voluntarily, I give my consent for treatment of my painful condition with opioid medications.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Witness (receipt of copy of agreement): _____