CONSENT FOR LONG TERM OPIOID THERAPY FOR PAIN CONTROL
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Patient's Name Date

Reason for taking long-term opioids:

The decision to use long-term opioids for pain control had been made because of my serious condition, or because other treatments have not helped my pain.

_____1. I am aware that the use of these medicines carries certain risks, including, but not limited to: sleepiness, drowsiness or dizziness, constipation, nausea, itching, vomiting, allergic reactions, slowed breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance, addiction, and the possibility that the medication will not provide complete relief.

_____2. I have been made aware of the possible risks and benefits of other types of treatments that do not involve the use of opioids. They have been discussed with me and include:

_____3. I have informed my doctor about all other medicines and treatments that I am receiving or have recently received.

_____4. I am aware that certain other medications, such as Nalbuphine (Nubain®), Pentazocine (Talwin®), Burenorphine (Beprenex®) and Butorphanol (Stadol®) may reverse the action of the medicine I am being given for pain control. Taking any of the drugs above may cause serious and uncomfortable withdrawal symptoms. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid pain medicine, and cannot take any of the above listed medications.

_____5. I understand that ***addiction*** is defined as: the use of a medicine even if it causes harm, having cravings for a drug or feeling the need to use a drug, which may decrease quality of life. I am aware that the chance of becoming addicted to pain medicine is low, but still possible. I am aware that the development of addiction is much more common in a person who has family or personal history of addiction. I agree to honestly inform my doctor of my complete personal drug history, and that of my family to the best of my knowledge.

_____6. I understand the ***physical dependence*** may be anticipated from using these medicines for a long time, but that it is not the same as addiction. Physical dependence means that if my pain medicine is abruptly or markedly decreased, stopped or reversed by certain agents, I will experience withdrawal symptoms. These may include runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, body aches and flu-like feelings. I understand that withdrawal symptoms are uncomfortable and undesirable, but not life threatening.

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_____7. I am aware that ***tolerance*** to analgesics means that I may require continuing higher doses of medicine to get the same amount of relief. Increasing dosage may not always help, and may cause undesirable side effects. Tolerance or failure to respond well to opioids may force the choice of another treatment plan.

Males Only:

_____ I understand that chronic use of opioids has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire, and physical and sexual performance. I understand my doctor may test my blood to see if my testosterone levels are normal.

Females Only:

_____ If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will ***immediately*** **call to inform my obstetric physician – and *this office***. I am aware that should I carry a baby to delivery while taking these medications, the baby will be physically dependent on opioids. While the use of opioids is not always associated with birth defects, there is the chance that the baby will be born with birth defects.

Medication Management Agreement:

- We will send a letter to your primary care doctor, and any other doctor you designate, with a copy of this agreement. We will request that your primary care doctor **not** prescribe any opioids for you. You will agree not to ask your primary care doctor, or any other doctor, for opioid medications.
- **You will have all of your prescriptions filled at your choice of only one pharmacy, which is:**

Pharmacy Name:_____

Pharmacy Phone:_____

Pharmacy Address:_____

_____

_____8. I authorize my doctor to provide a copy of this agreement to my designated pharmacy.

_____9. If I change pharmacies for any reason, I agree to notify my doctor when s/he writes my next prescription. I agree to provide my new pharmacy with the name and phone number of my previous pharmacy.

_____10. Knowing this treatment requires my full cooperation; I agree to keep all scheduled appointments. If unable to keep an appointment, I will call well in advance to discuss with my doctor the reason for not keeping the appointment.

_____11. I will not use any illegal controlled substances such as marijuana, cocaine, etc.

_____12. I agree to submit to a blood or urine test at any time to determine my compliance with this agreement and my schedule of medication.

_____13. I will not share, sell or trade my medication for money, goods or services.

_____14. I will not attempt to obtain pain medication from any other health care provider without telling them that I am taking the medication prescribed by this office. I understand that it is against the law to do so. If my primary care physician is willing to prescribe my opioid medication, this office will have to approve the arrangements to make sure there is no duplication of medication.

_____15. I will discontinue all previously used pain medications unless told otherwise.

_____16. I will safeguard my medications from loss or theft, and understand that the consequences of my failure to do so is that *I will be without prescribed medication for a period of time*, possibly leading to withdrawal symptoms.

_____17. I agree to waive any applicable privilege or right to privacy or confidentiality with respect to the prescribing of my medication. I authorize my doctor and pharmacy to cooperate fully with any city, state, or federal law enforcement agency in the investigation of my possible misuse, sale or other diversion of my pain medication.

_____18. I agree to use my medication at a rate not greater than the prescribed rate and understand that by doing so I will be without my medication for a period of time. Using this medicine in excess could possibly cause my death!

_____19. Prescription refills will be authorized **only** during regular office hours on weekdays (NO WEEKENDS). We understand emergencies may occur and those will be considered on an individual basis.

_____20. I agree to comply fully with all aspects of my treatment program. Failure to do so may lead to discontinuation of medication and referral to another health care provider.

- **Take your medication only as prescribed and directed**
- **Opioids may cause drowsiness**
- **Avoid alcohol while taking this medication**
- **Use care when driving or operating machinery**
- **Overdose of opioids may cause severe side effects, even death!**
- **Federal law prohibits transferring this medication to anyone else**

_____21. I have read this form, or have had it read to me. **I understand all of it**. I have had a chance to ask questions and all of them have been answered to my satisfaction. By signing this form voluntarily, I understand that I give my consent for treatment of my pain with opioid pain medicines. I agree to follow all the guidelines contained in these pages. I understand that if I do not cooperate fully, my doctor may taper off and stop my medications and refer me elsewhere for care. A copy of this document has been given to me.

Patient's Signature Date

Doctor's Signature Date

Witness' Signature Date