Spine & Pain Centers, PA
Opioid/Scheduled Medication Treatment Agreement

Patient Name: _____ Date: _____

Date of Birth: _____

Our practice is committed to doing all we can to treat your chronic pain condition. In some cases, controlled substances are used as a therapeutic option in the management of chronic, pain, which is strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper and controlled substance use. The word "physician" refers to your physician, a covering physician or any medical provider at Spine and Pain Centers, PA and the word "you" refers to the patient.

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/scheduled medications to treat pain.

The long-term use of such substances as opioids (narcotic analgesics), scheduled medications such as tramadol, benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged For this reason, the following policies are agreed to by you, the patient, as consideration for, and a condition of the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

Medications being prescribed today: _____

_____

Please note that changes in medication may occur during the course of treatment and alternative modes of treatment maybe be part of the treatment plan.

1. You should use one physician to prescribe and monitor all opioid/scheduled medications and adjunctive analgesics.

2. You should use one, pharmacy to obtain all opioid/scheduled prescriptions and adjunctive analgesics prescribed by your physician.

Pharmacy: _____ Phone Number: _____

3. You should inform your physician of all medications you are taking, including herbal remedies, since opioid/scheduled medications can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine or hydrocodone. Call 732-345-1180

4. You will be seen on a regular basis and given prescriptions for enough mediation to last from appointment to appointment; plus usually two to three days extra. This extra medication is not to be used without the explicit permission of the prescribing physician unless an emergency requires your appointment to be deferred one or two days.

5. Prescriptions for pain medicine or any other prescriptions will be done only during your office visit or during regular office hours. No refills of any medications will be done during the evening or on weekends.

6. Early refills will generally not be given. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date. Narcotic/scheduled prescriptions cannot be mailed to the patient.

7. You are responsible for keeping your pain medication in a safe and secure place, such as a locked cabinet or safe. You are expected to protect your medications from loss. or theft. Stolen medications should be reported to the police and to your physician immediately. If your medications are lost, misplaced or stolen, your physician may choose not to replace the medications or to taper and discontinue the medications. If you decide to discontinue the opioid/scheduled medication, you are required to properly dispose of the medication either by bringing them to your Pharmacy/Police Department and placing in a medication "Drop Box" or placing unwanted medications in a cup with a substance that renders the medication undesirable for consumption, such as cat litter or coffee grounds prior to throwing in the trash.

8. You may not give or sell your medications to any other person under any circumstances. If you do, you may endanger that person's health. It is also against the law.

9. Any evidence of drug hoarding, acquisition of any opioid/scheduled medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.

10. You will communicate fully to your physician to the best of your ability at the initial and all follow-up visits your pain level and functional activity level along with any side effects of the medications. This information allows your physician to adjust your treatment plan accordingly.

11. You should not use any illicit substances, such as cocaine, marijuana. etc. while taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your opioid/scheduled medications when applicable, or complete termination of the doctor/patient relationship.

12. The use of alcohol and opioid/scheduled medications together should be avoided.

13. You agree and understand that your physician reserves the right to perform random or unannounced serum toxicology or urine drug testing. If requested to provide a urine sample, you agree to cooperate. Payment for the drug screening will ultimately be your responsibility but as a courtesy the bill will be submitted to your insurance company for you.

14. If you decide not to provide a blood or urine sample, you understand that your doctor may change your treatment plan, including safe discontinuation of your opioid/scheduled medications when applicable, or complete termination of the doctor/patient relationship. The presence of a nonprescribed drug(s), illicit drug(s) or alcohol in the urine can be grounds for termination of the doctor/patient relationship. Urine drug testing is not forensic testing but is done for your benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.

15. There are side effects with opioid/scheduled medication therapy, which may include, but not exclusively, skin rash, constipation, nausea, itching, vomiting, dizziness, allergic reaction, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, impaired cognitive (mental status) and/or motor ability, physical dependence, tolerance to analgesia, addiction, and possibility that the medicine will not provide complete pain relief. Overuse of opioids/scheduled medications can cause decreased respiration (breathing). Due to these possible side effects we strongly recommend that you do not drive or operate vehicles and heavy machinery while taking these medications.

16. Physical dependence and/or tolerance can occur with the use of opioid/scheduled medications. Physical dependence means that if the opioid/scheduled medication is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is not a normal physiological response. The withdrawal syndrome could include, but not exclusively, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in one's mood.

It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to tr at diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.

Addiction is a primary, chronic neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life.

Tolerance means a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time. The dose of the opioids/scheduled medications may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain.

17. If you have a history of alcohol or drug misuse/addiction, you must notify the physician of such history since treatment with opioids/scheduled medications for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid/schedu1ed medications treatment of pain, but starting or continuing a program for recovery is a must.

18. You agree to allow your physician to contact any healthcare professional, family member, pharmacy, legal authority. or regulatory agency to obtain or provide information about your care or actions if the physician feels is necessary.

19. You agree to a family conference or a conference with a close friend or significant other, if the physician feels it is necessary.

20. Your physician has the right to change or discontinue certain medications according to their medical judgment.

NOTE: The drug screen will show if you have the prescribed medication and dosage in your system as well as test for the presence of illegal drugs. If you test positive for illegal substances, you may be discharged from the practice.

I have read this agreement and fully understand all its terms, conditions and consequences. I agree to its terms so that Dr. _____ can provide quality pain management using opioid/scheduled medications therapy to decrease my pain and increase my function.

Patient's Signature: _____ Date: _____

Witness's Signature: _____ Date: _____

Opioid/Scheduled Medication Therapy for Pain: Informed Consent*

Please review the information listed here and put your initials next to each item when you have reviewed it with your provider and feel you understand and accept what each statement says.

_____ My provider is prescribing opioid pain medications for the following condition(s):

_____

_____ When I take these medications, I may experience certain reactions or side effects that could be dangerous, including sleepiness or sedation. constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing of my breathing.

_____ When I take these medications, it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused, or otherwise impaired by these medications, I should not do things that would put other people at risk for being injured.

_____ When I take these medications regularly, I may become physically dependent on them, meaning that my body may become accustomed to taking the medications every day, and I may experience withdrawal sickness if l stop them or cut back on them too quickly. Withdrawal symptoms feel like having the flu, and may include abdominal pain nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, yawning, anxiety, and sleep problems.

_____ I may become addicted to these medications (even when taking as prescribed) and require addiction treatment **if** l cannot control how I am using them or **if I** continue to use them even though I am having bad or dangerous things happen because of the medications.

_____ Anyone can develop an addiction to opioid pain medications, but people who have had problems with mental illness or with controlling drug or alcohol use in the past are at higher risk. I have told my provider if I or anyone in my family has had any of these types of problems.

_____ Taking too much of my pain medication, or mixing my pain medications with alcohol, drugs, psychiatric medicine, or other medications that cause sleepiness, such as benzodiazepines, barbiturates, and other sleep aids, could cause me to be dangerously sedated or to overdose and stop breathing and my result in my death.

_____ I understand that taking certain medications such as buprenorphine (Suboxone, Subutex, naltrexone (ReVia), nalbuphine (Nubain), pentazocine (Talwin), or butorphanoi (Stadol) may reverse the effects of my pain medicines and may cause me to go into withdrawal.

_____ It is my responsibility to tell any provider that is treating me or prescribing me medications that I am taking opioid pain medications so that they can treat me safely and do not give me any medicines that may interact dangerously with my pain medicines.

_____ I have discussed the possible risks and benefits of taking opioid medications for my condition with my provider and have discussed the possibility of other treatments that do not use opioid medications including: injections, non-opioid medications, anti-inflammatories, antispasmodics, physical therapy, chiropractic and acupuncture.

_____ These medications are being prescribed to me because other treatments have not controlled my pain well enough.

_____ These medications are to be used to decrease my pain, but they may not take away my pain completely.

_____ These medications are to be used to help improve my ability to work, take care of myself and my family, and meet other goals that I have discussed with my provider, but if these medications do not help me meet those goals, they may be stopped.

_____ **FOR MEN:** Taking opioid pain medications chronically may cause lower testosterone levels and affect sexual function.

_____ **FOR WOMEN:** It is my responsibility to tell my provider immediately if I think I am pregnant or if am thinking about getting pregnant. If I become pregnant while taking these medications and continue to take the medicines during pregnancy, the baby may be physically dependent on opioids at the time of birth and may require withdrawal treatment.

I have reviewed this form with my provider and have had the chance to ask questions. I understand each of the statements written here and by signing give my consent for treatment of my pain condition with opioid medications.

_____	_____	_____
Patient signature	Patient name printed	Date
_____	_____	_____
Witness Signature	Witness name printed	Date

*Adapted from the American Academy of Pain Medicine