COMPREHENSIVE PAIN CENTER AGREEMENT FOR TREATMENT OF PAIN WITH OPIOIDS: INFORMED CONSENT

This agreement relates to my use of opioids for chronic pain prescribed by the doctors at Comprehensive Pain Management. I recognize these are policies regarding the use of controlled substances followed by the staff. Treatment of chronic pain with opioids is controversial. My physician is under no obligation to prescribe these medications for me. This decision is based on professional judgment of my pain clinic doctor to improve my ability to participate in work and social activities. This decision that I have made after fully discussing the risks and benefits of opioid medications as well as other treatment options.

NARCOTIC PRESCRIPTIONS:

1 ***All*** prescriptions should be made ***AT*** the appointment
2 If missed, prescriptions need to be ***picked up*** at the office, will ***NOT*** be mailed You need to give a weeks notice
3 Narcotics will ***NOT*** be changed over the phone, you must be do it at an appointment.
4 No refills will be made ***over the phone*** after office hours
5 Remember you are responsible for these medication and ***"loss", " "run out of early", or "spill"*** are ***Not*** valid reason for an early refill.
6 Do ***NOT*** seek narcotics from any other source, if a script is written, you will need to notify our office ,or this will be considered a breech of our narcotic policy.
7 ALL appointments are important, more than 2 "no shows" you may be discharged from the practice.

If it appears to the physician that there are no demonstrable benefits to my daily function from these opioids, suspected addiction, rapid tolerance, loss of effect or significant and detrimental side effects, I will gradually taper my medication as prescribed by the physician. If a drug addiction problem is suspected, I may be referred to another health care provider for management of the addiction. I will not hold any member of Comprehensive Pain Center liable for problems caused by discontinuance of controlled substances, provided that I receive 30 days notice of termination.

I will come to my scheduled appointments prepared to submit to urine and blood samples to assess the effect of the opioids and my compliance to my treatment plan. If my drug test is positive for illicit drugs or narcotis not prescribed by this office, I understand I will be weaned off the narcotics and discharged from the practice. I understand this could be a lethal combination.

RISKS

I understand that these medications have potential risks, the most significant being:.Physical dependence. Abrupt stopping of the drug will lead to withdrawal syndrome characterized by abdominal cramping, diarrhea, "goose flesh", and anxiety.Psychological dependence or addiction.It is possible that stopping of the drug will cause me to miss or crave it. Overdose of the opioid. This can lead to respiratory arrest and death. Mental Changes. This may result in confusion, changes in thinking abilities and problems with coordination and balance. I will use caution and common sense before operation of equipment or motor vehicles. Contacting my pain physician. I must contact my pain physician before taking any other drugs. Medications like Valium, and Ativan, sedatives such as Soma, Xanax, Fiorinal, antihistamines like Benadryl, and alcohol may produce profound sedation, respiratory depression, blood pressure drop, and even death when taken with opioids.

Any violation of this contract will result in a discontinuation of treatment with opioid medication, and possible discharge from the practice. I have read this document, understand it and have had all questions answered satisfactorily. I agree to all conditions of this opioid contract.

_____ _____ _____/_____/_____
Patient Signature Patient's name (printed) Date

I certify that I have explained this contract including the risks and benefits and answered any question for the above signed individual.

_____ _____ _____/_____/_____
Physician/PA Signature Physician/PA Name Date

I have translated the information and advice presented orally to the individual giving consent by the person obtaining this consent. To the best of my knowledge and belief, he/she understands this explanation.

_____ _____/_____/_____
Interpreter Signature If applicable Date

Revised 01/2007 ek

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