Community Principles of Pain Management

Pain Management Agreement and Informed Consent

Approved in June 2019; Next Scheduled Update in 2021

Patient Name: ________________________________ Medical Record#: _________________

Medicines called opioids (o-pee-oyds) have been prescribed for my chronic pain. Opioids are sometimes called narcotics. I understand they may be helpful. I also recognize that these medicines are dangerous if not taken correctly. They may be misused. Because of possible danger and misuse, they are closely controlled by my medical providers and by law. The following conditions will help give me the best pain relief and avoid misuse. I agree to follow them:

______ **1. I will take my pain medicines correctly.** I agree to take the medicine only as prescribed. I will contact my provider before making any changes.

- I understand that taking more of my medicine than prescribed could lead to a **drug overdose.** An overdose may cause my heart or breathing to become very slow or stop. This could lead to death.
- I understand that physical dependence is normal and expected when using these medicines for a long time. I understand that physical dependence is not the same as addiction. I understand that decreasing or stopping my medicine suddenly could lead to **withdrawal symptoms**. These include sweating, chills, and joint pain. I may also have trouble sleeping or be sick to my stomach. If I need to stop taking my medicine, I will follow my provider's direction to do so slowly.
- I understand that my pain medicine may cause **addiction or opioid use disorder**. Addiction means a lack of control over the use of the medicine. Lack of control includes using the medicine in spite of harm to me or craving the medicine. Harm could be physical, mental or social.
- I understand that **tolerance** means that I may require more medicine to obtain the same amount of pain relief. Taking more medicine may not lessen my pain. Instead, it may cause distressing side effects. Tolerance or failure to respond well to my medicine may lead my provider to choose another form of treatment.
- I understand that my provider will review the effect of my medicine with me on a regular basis. If my quality of life does not get better, the medicine may be stopped. In that case, I will follow my provider's direction to slowly stop my opioid medicine.

______ **2. I will report side effects.** I understand that there are side effects from my opioid medicine. I will tell my provider at my next appointment about any side effects that are new, don't go away, or affect my thinking. These may include:

- Drowsiness
- Confusion
- Constipation
- Nausea
- Hallucinations (seeing things that aren't there)
- Vomiting
- Itching
- Dizziness
- Slowed breathing
- Slowed reaction times

For most people, these side effects decrease with continued use of the medicine.

- I will not involve myself in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. Such activities include but are not limited to:
  - Driving a motor vehicle or using heavy equipment
  - Being responsible for another individual who is unable to care for himself

______ **3. I will tell all of my medical providers that I am taking opioid medicine. I understand that other medicines and substances can affect the way opioid medicines work in my body.**

- I understand that taking opioid medicines with alcohol may cause:
  - very slow breathing
  - very low blood pressure
  - extreme drowsiness
  - and even death.
- I understand that I should not drink alcohol or take medicines containing alcohol while taking my opioid medicine.
- I understand that I must talk with my provider before taking other medicines.
  Some common medicines that may interact with my opioid include:

    - Anxiety medicines (example: lorazepam (Ativan), diazepam (Valium), alprazolam (Xanax))
    - Muscle relaxers (example: cyclobenzaprine (Flexeril))
    - Sleeping medicine (example: zolpidem (Ambien), over-the-counter sleep medicine)
    - Allergy/cold medicine (example: diphenhydramine (Benadryl)
    - Medical Marijuana

- I will tell my provider as soon as possible if I need to visit another provider or the Emergency Room due to pain. If I go to the Emergency Room, I will tell the Emergency Room provider that I have signed this pain agreement. Failure to do so may result in my discharge from care.

______ **4. I will not use street drugs while on opioid medicine.** If I have misused substances or alcohol in the past, I have discussed this with my provider. I agree to provide urine and blood for drug screening at any time my provider asks me. These tests will show the use of prescription and street drugs.

- I will not use any drugs that were not prescribed for me.

______ **5. I will tell my provider right away if I become pregnant or am planning to become pregnant.**

______ **6. I will keep my appointments.**

______ **7. I will keep track of my medicine and prescription refills.** I understand that prescription refills:

- Will be written for a time period that my prescriber believes is safe.
- Will **not** be given if I:
    - Run out early
    - Lose the prescription
    - Spill or misplace the medicine
    - Have the medicine stolen.
- Will be refilled at the same pharmacy unless I have made other plans with my provider.

______ **8. I will keep my opioid medicine safe in a LOCKED place.**

- I understand that the opioid medicine is **only for my use**. The medicine should never be given or sold to others.
- If I have children in the house, I will ask the pharmacy for a childproof top.
- If my medicine is stolen, I will report this to my local police department. I will also get a stolen item report.
- I will safely dispose of unused opioid medicine.

______ **9. I have received education about my opioid medicine. I have had the chance to ask my provider questions about my opioid medicine.**

______ **10. I understand that I need to follow all of the above conditions. If I do not follow these conditions, my provider may no longer prescribe opioid medicines for me.** I also understand that if I have a problem or question with any of the above information, I will discuss this with my provider.

______ **11. I understand the importance of obtaining my opioid prescription from one prescriber and one pharmacy.**

My <u>Prescriber</u> I agree to obtain my opioid prescription from: ______________________________

My <u>PHARMACY</u> I agree to obtain my opioid prescription from: ______________________________

I will report side effects to: ____

The <u>OPIOID</u> medicine that I have been prescribed is: ______________________________________

I understand that the effect of my medicine will be reviewed with my provider on a regular basis. If my daily function or quality of life does not get better from the opioid medicine, it may be stopped. In that case, I will follow my provider's direction to slowly stop my opioid medicine.

I have read the above information (or it has been read to me) and have received a copy of the agreement. I understand my responsibilities and agree to these conditions while receiving opioid medicines.

______________________________	______________________________
Patient Signature	Witness Signature
______________________________	______________________________
Prescriber Signature	Date