HIGHLAND FAMILY PRACTICE
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Consent for Chronic Pain Opioid Therapy

My provider is prescribing opioid medicine, sometimes called narcotic analgesics, to me for a diagnosis of (circle all that apply): headache, back pain, neck pain, shoulder pain, arm pain, hand pain, abdominal pain, hip pain, pelvic pain, knee pain, ankle pain, foot pain, or other pain: _____.

This decision was made because my condition is serious or other treatments have not helped my pain. I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief. If I take more medication than prescribed, a dangerous situation could occur that could result in coma, organ damage, or death.

I am aware about the possible risks and benefits of other types of pain treatments that do not involve the use of opioids. The other treatments include: do nothing, non-narcotic medications, physical therapy, injections, surgery, etc.

I will tell my doctor about all other medicines and treatments that I am receiving.

While taking opioids for pain control, I will not be involved in any activity that may be dangerous to me, or someone else, if I feel drowsy, or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction times might still be slowed. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working at unprotected heights, or being responsible for another individual who is unable to care for himself or herself. If there is any question of impairment, I agree not to perform such activities until a physician has properly evaluated me.

I am aware that certain other medicines such as nalbuphine (Nubain ™), pentazocine (Talwin™), buprenorphine (Buprenex™), and butorphanol (Stadol™), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain control medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid and cannot take any of the medicines listed above, unless they are prescribed by my provider from Highland Family Practice.

I am aware that opioid addiction is defined as the use of an opioid medicine, even if it causes harm, causes cravings for the opioid medication, or causes a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of opioid addiction. I agree to tell my doctor my complete and honest personal drug history, and that of my family, to the best of my knowledge.

If placed on methadone, I am aware that the duration of action of methadone may be longer than the actual pain relieving affects of this drug. Also, my doctor will obtain an EKG initially and routinely, due to the fact that there may be adverse side effects from higher doses of methadone.

I understand that physical dependence is a normal, expected result of using these opioid medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence

means that if my opioid medicine use is markedly decreased, stopped, or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable, but not life threatening.

I am aware that tolerance to analgesia means that I may require more opioid medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with opioid addiction, however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance, or failure to respond well to opioids, may cause my doctor to choose another form of treatment.

(Males Only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is 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 my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

I have read this form, or have had it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines.

Name:_____ DOB:_____

Signature: _____ Date: _____

Witness: _____ Date: _____

Revised: 01/16/2019