Physicians Pain Services

Patient Name:_____**DOB:**_____

Opioid Therapy Agreement

I understand that my provider with Physicians Pain Services may prescribe opioid medication to assist me in managing chronic pain that has not responded to other treatments. The goal of the opioid therapy will be to assist me to improve my daily functioning. If my activity level or general functioning gets worse, the medication may be changed or discontinued. The risks, side effects, and benefits have been explained to me and I agree to the following conditions of opioid treatment. I understand that my Doctor/Nurse Practitioner is under no obligation to provide these medications to me, and that he or she reserves the right to discontinue these medications at any time.
Additionally, failure to adhere to these conditions below will result in discontinuing the opioid medication.

1. I agree to participate in **other treatments** which my provider may recommend. I will be ready to taper or discontinue my opioid medications as other effective treatments become available.

2. I will take my medications exactly **as prescribed** and will not change the medication dosage or schedule without my provider's approval. If I need a medication change or refill I must **make an appointment** with my provider.

3. I will **inform my provider** of ALL medications and new medications that I am on (prescribed, OTC, & herbal). I will bring my current medication list with me to all of my appointments.

4. I will **bring in my prescribed pain medications** with me to every appointment AND may be asked at any time to bring in medications for a random **pill count** per my provider's request. Medications must be brought in within 24 hours of request.

5. I will **keep regular appointments** with my provider and all other providers as recommended. Two appointment cancellations within less than one working day's notice or two no-show appointments may constitute grounds for immediate termination of this agreement. There will be **no short scripts** given for missed or canceled appointments.

6. All opioid and other controlled drugs must be prescribed ***only*** by Dr. Boedefeld or Dr. Shelton.

7. If I have another condition that requires the prescription of a controlled drug (like narcotics, tranquilizers, barbiturates, or stimulants), or if I am hospitalized for any reason, I will inform my provider within one business day.
8. I will designate **one pharmacy** where all of my prescriptions will be filled. If I must use another pharmacy for any reason, I must contact my provider before doing so.

9. I understand that lost or stolen prescriptions will NOT be replaced, and I will not request early refills.
10. I will abstain from using all illegal drugs, sedative medications, and alcohol with any opioids. The use of opioids with other medications such as benzodiazepines or alcohol can be serious and life threatening. I will inform my health care provider of all medication changes.
11. I will protect my prescriptions and medications. I will keep them in a safe, secure place that is away from children and others.
12. I am responsible for keeping track of the medication left and plan ahead for arranging refills in a timely manner so that I will not run out of medications.
    a. Refills will be made only during regular office hours, which are 8am to 4 pm.
    b. Refills will NOT be made at night, Fridays after 12 noon, weekends or during holidays.

I understand that my doctor may stop prescribing opioids or change the treatment plans if:

a. I do not show any improvement in pain from opioids, or my physical activity has not improved.
b. My behavior is inconsistent with the responsibilities outlined in #1 above.
c. I give, sell, or misuse the medications.
d. I develop rapid tolerance or loss of improvement from the treatment.
e. I obtain opioids from anyone other than this provider.
f. I refuse to cooperate when asked to get a drug screen.
g. If an addiction problem is identified as a result of prescribed treatment or any other substance abuse.
h. If I am unable to keep follow-up appointments.
i. If I am requesting regular prescriptions, and my medication does not show up in the specimen sample.

I understand the compliance with these guidelines are important in continuing pain treatment with Physicians Pain Services.

Patient Signature: _____ **Date**: _____

OPIOID RISKS AND SAFETY CONCERNS

SIDE EFFECTS OF OPIOIDS:

- Confusion, clouded judgment, or other change in thinking abilities.
- Problems with coordination, reaction time, or balance that may make it unsafe to operate dangerous equipment or motor vehicles.
- Breathing too slowly-overdose can stop your breathing and lead to death
- Nausea or Vomiting
- Sleepiness or drowsiness
- Constipation
- Depression
- Dry mouth

****THESE SIDE EFFECTS MAY BECOME WORSE IF YOU MIX OPIOID WITH OTHER DRUGS, INCLUDING ALCOHOL.**

****Benzodiazepines have a BLACK BOX WARNING, which warns that taking benzodiazepines at the same time as opioids can lead to extreme sedation, slow and ineffective breathing, comas, and even death.**

RISKS ASSOCIATED WITH OPIOID USE:

- **Physical dependence**- This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following: Runny nose, difficulty sleeping for several days, diarrhea, abdominal cramping, sweating, “goose bumps”, rapid heart rate, nervousness.
- **Psychological dependence**- This means that it is possible that stopping the drug will cause you to miss or crave it.
- **Tolerance**- This means that you may need more and more drug to get the same effect.
- **Addiction**- Some patients may develop addiction problems based on genetic or other factors.
- **Problems with Pregnancy**- If you are pregnant or contemplating pregnancy, discuss with your physician.

RECOMMENDATIONS TO MANAGE YOUR MEDICATIONS:

- Keep a **diary** of the pain medications you are taking, the medication dose, time of day you are taking them, their effectiveness and any side effects you may have.
- Use a **medication box** that is divided into the days of the week and times of day so it is easy to remember when to take your medications. You can purchase one at your pharmacy.
- Take along only the amount of medicine you need when leaving home so there is less risk of losing all your medications at the same time.

****I have read this document, understand and have had all my questions answered. I consent to the use of opioids to help control my pain, and I understand that my treatment with opioids will be carried out as described above.**

Patient Signature: **Date**:

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