MANHATTAN
PAIN MEDICINE

Opioid Therapy Informed Consent

ADAPTED FROM A CONSENT FORM FROM THE AMERICAN ACADEMY OF PAIN MEDICINE

The provider is prescribing opioid medicine, sometimes called narcotic analgesics, to me for a pain-related diagnosis. Opioid therapy for pain includes any and all natural or synthetic opiates or opioids, including, but not limited to, morphine, oxycodone, hydrocodone, hydromorphone, codeine, tramadol, methadone, and buprenorphine. I understand that opioid therapy is elective, which means that it is not a required treatment and is not life-sustaining.

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, possibility that the medicine will not provide complete pain relief, and possibility of more severe pain as a result of opioid-induced hyperalgesia.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed included non-opioid medications, injections and physical therapy.

I am aware the prescription of opioid medication requires regular scheduled office visits for evaluation and continued prescription. I am aware that if I miss a scheduled appointment, I may be left without medication, and it is my responsibility to reschedule an appointment prior to running out of medication. I understand that if I do indeed run out of medication before a scheduled appointment, or as a result of missing an appointment, my physician is in no way responsible for any ill effects I may experience. I am also aware that I must bring my prescription bottles with the remaining medication to each office visit.

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I am aware that combining my pain medication with certain other prescribed or non-prescribed medications, drugs or substances may affect the way my body processes the pain medication. I will tell my doctor about all other medicines and treatments that I am receiving or taking on my own without physician supervision. I am aware that my physician will randomly check my urine for the presence of the prescribed medication as well as any other substances, and I will be responsible for the cost of this testing. I am aware that if the drug testing is not consistent with my prescription, or if other controlled substances are being prescribed by another provider without my physician's prior knowledge, opioids will not be prescribed and I may be immediately discharged from the practice.

I am aware that alcohol, when combined with opioids, may be lethal. I agree to not drink alcohol while taking opioid pain medicine.

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 time might still be slowed. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

I am aware that certain other medicines such as nalbuphine (Nubain™), pentazocine (Talwin™), buprenorphine (Buprenex™ or Suboxone™), 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 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 as my pain medicine and cannot take any of the medicines listed above.

I am aware that addiction is defined as the use of a medicine, drug or substance even if it causes harm, having cravings for a drug, feeling the need to use a drug, prioritizing the need to acquire the drug over other essential daily activities, and a decreased quality of life. I am aware that I may become addicted to my pain medicine. I am aware that the development of addiction has been reported in

medical journals and is much more common in a person who has a family or personal history of 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. I also agree to tell my doctor if I feel that I am becoming addicted to the medication.

I understand that physical dependence is a normal, expected result of using these 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 pain 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, goosebumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable and may be life threatening for some individuals. I agree to contact my physician if I feel any of these symptoms.

I am aware that tolerance to analgesia means that I may require more 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 chronic pain, 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. I am aware that if I develop tolerance, or if the pain relief is inadequate (as determined by no improvement in physical function), this will be considered a therapeutic failure, or failure of the medication as a treatment for my condition, and my doctor may wean and discontinue opioid therapy and 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 understand that opioids affect my body in many unintended ways, and that these effect may include, but are not limited to, death, decreased bone density (osteoporosis), increased risk of fall and bone fracture, sleep disturbance, constipation, mood change, drowsiness, impaired decision making, urinary retention (inability to urinate), vision changes, worsening of pain, development of tolerance, dependence or addiction.

I am aware that insurances and pharmacies may require additional steps to access to opioid medications. Extra paperwork may need to be completed by my physician, and I agree to pay for any associated administrative costs at the time of service.

I have read this form or have had it read to me. I understand all of it. I have had a chance to ask questions and 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, and affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand, and accept all of its terms.

Patient name(print):_____

Signature: _____ Date:_____

Provider Signature:_____