

MEDICATION AGREEMENT

Patient's Full Name (printed legibly): _____ DOB: _____

My doctor at Pain Relief Centers is prescribing an opioid medication, sometimes called a narcotic analgesic, which is classified as a controlled substance. State and federal laws and guidelines regulate these medications. This decision was made because my condition is serious or other treatments have not helped my pain. I am aware that this type of medicine has certain risks associated with it, including, but not limited to: sleepiness, constipation, nausea, itching, vomiting, dizziness, allergic reactions, slowing breathing rate, slowing of reaction time, physical dependence, tolerance to analgesia, addiction, ineffective pain control or death.

I will only obtain prescriptions for controlled medications from the physicians at Pain Relief Centers, unless otherwise directed or agreed upon by the Pain Relief Centers. I will notify Pain Relief Centers of all other medications I am taking.

I am aware there are other treatments for my symptoms that do not involve the use of opioids. Other possible treatments include non-opioid medications, behavior modifications, physical therapy, diet and weight loss/control, quitting smoking, surgery, and interventional procedures.

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, my reflexes and reaction time might be slowed and affect my ability to safely complete certain activities. 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 him or herself.

I am aware that certain other medications 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 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 opioids as my pain medicine and cannot take any of the medicines listed above.

I understand that using alcohol containing products while taking many medications, including pain medicine, is not recommended and may increase my risk of side effects from the medication. These include but are not limited to sedation, respiratory depression and death.

I am aware that addiction means using a medicine even if it causes harm, having cravings for a drug, and feeling the need to use drug even though it and a results in 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 addiction. I agree to tell my doctor my complete personal and family drug history to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medications 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 agents mentioned above, I will experience withdrawals symptoms. This means I may have any 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 opioids withdrawal is uncomfortable and may require further treatment.

I am aware that the long-term use of opioid medications may result in ineffectiveness over time and may require the change or discontinuation of therapy. My doctor may also recommend other forms of treatment to help control my symptoms.

(Males Only) I am aware that chronic opioids use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and sexual performance.

(Females Only) If I plan to become pregnant or believe that I am pregnant while taking pain medicine, I will immediately call my obstetric doctor and the Pain Relief Centers to notify them. I am aware that, should I carry a baby to delivery while taking these medicines, that the baby may 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 are possible for mothers taking pain medicine.

I understand if I feel my symptoms are not adequately controlled with my treatment regimen, I may seek care elsewhere.

I have read this form or have had it read to me. I understand all of it. I have had the chance to have all 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.

Patient Signature: _____ Date: _____

Witness to above: _____ Witness printed name: _____ Date: _____

copy of consent given to patient