



PAIN MEDICATION INFORMATION

We request that all of our patients review this Pain Medication Agreement on their first visit to our office.

We believe it is important that you understand the risks of taking Opioid/narcotic pain medications as well as our commitment to work with you to ensure that your pain is managed in a safe and effective manner.

If you require Opioid (narcotic, “pain killer”) medication in the course of your treatment with Peachtree Orthopaedic Clinic, you will be required to sign the Pain Medication Agreement. Attached you will find that consent along with information about Opioid/narcotic pain medications.

You will be asked to sign the attached Pain Medication Agreement the first time you receive a prescription for Opioid/narcotic pain relieving medications.

Thank you for participating actively in your care.



PAIN MEDICATION AGREEMENT

You have agreed to receive Opioid (narcotic, “pain killer”) medication to manage your pain. You must have an understanding of the risks and responsibilities that go along with this treatment. Please read each statement and sign this agreement/contract below.

YOUR HEALTH PROBLEM

You have a pain control problem. You have requested treatment with opioid (narcotic) pain medication because other therapies, treatment, and/or medication(s) that you have previously received had not provided adequate pain relief. Your alternative is to continue with your current treatment.

THE GOAL OF OPIOID PAIN KILLER DRUGS

The purpose of prescribing this medication is to decrease pain and improve function. It is unlikely that any medication(s) will completely remove or eliminate the pain. It is expected that use of this medication(s) will improve function.

Facts: *Over half of all patients taking oral opioid medication will experience at least one side effect or complication.

*While opioid treatment may be prescribed to reduce pain and improve function, the treatment may actually do just the opposite.

Side Effects: Common side effects include nausea, vomiting, itching, drowsiness, constipation, and difficulty with urination.

Potential Complications: Many complications are possible including mental or cognitive impairment, slowed breathing, decreased testosterone levels, irregular menses, reduced sexual desire, worsening of any level of anxiety or depression, psychological dependency, physical dependence, physical dependence of newborn if taken during pregnancy, opioid withdrawal, drug tolerance, addiction, suppression of the immune system and hyperalgesia (increased pain sensitivity).

Life-Threatening Complications: These include suicide, overdose, coma, organ damage or failure especially of kidney and liver, death. Use of these medications is one of the leading causes of injury or death in the United States.

PATIENT RESPONSIBILITIES RE: OPIOIDS/NARCOTICS

By signing the final page of this form, you agree that you understand the rules for taking Opioid (narcotic) pain relieving medications. The following guidelines establish the rules for the use of these controlled substances.

1. I understand the possible side effects and complications of pain relieving (opioid) medications.
2. I will be in charge of keeping the medications safely in my care. Lost or stolen medications may not be replaced until it is time for the next refill. I will prevent children, family members or any others from gaining access to these medications.
3. I agree to receive these medications only from the physicians or physician extenders (such as Physician Assistants or Nurse Practitioners) at Peachtree Orthopaedic Clinic.
4. Only one pharmacy may be used for filling pain relieving prescriptions.
5. **Pain relieving (Opioid/Narcotic) prescriptions should be requested during office visits.** It is my responsibility to ensure that I have enough medication to last through the weekends, holidays, and/or after hours.
6. I understand that it is against the law to make changes to a prescription after it is written.
7. I agree not to consume excessive alcohol, or no more than one drink (12 oz beer, 6 oz glass of wine, or one cocktail) in conjunction with prescribed opioid medication(s).
8. I will not use, purchase or obtain any illegal drugs while taking pain relieving (opioid) prescriptions.
9. **I agree to submit to random and/or scheduled urine and/or blood screens for drugs and other medications while I am receiving prescriptions for Opioids/Narcotics.**
10. I agree to allow Peachtree Orthopaedic Clinic physicians and their staff to contact pharmacists, referring physicians and other medical professionals involved in my care to discuss my medication(s).
11. I agree not to operate heavy or dangerous machinery, use firearms or weapons while taking opioid medication(s).
12. I agree not to drive if these Opioid medication(s) in any way alter my driving skills.
13. **Females ONLY:** I understand that taking Opioid medication(s) during pregnancy can result in harm to my baby or loss of pregnancy (miscarriage).
14. I agree that if I receive prescriptions for Opioid/narcotic medications from a source other than Peachtree Orthopaedic Clinic, this agreement may be voided and prescriptions of Opioid/narcotic medications may be discontinued.
15. I agree to take these medications **exactly** as instructed. I understand that any unauthorized increase in the dose of these medications may be viewed as a cause for stopping treatment with these medications.
16. I agree to keep all regular follow up appointments as recommended. I understand that failure to comply may be cause for stopping these medications.
17. **I understand that if I require Opioid beyond 45 days that:**
 - a. **I will have random and/or scheduled urine and/or blood screens for drugs and other medications.**
 - b. **My physician will focus on weaning me of opioids/narcotics**
 - c. **My physician may refer me to a Pain Management Physician**
18. **I understand that if I require Opioids beyond 90 days, I must be followed by a Pain Management Physician**

Consent and Agreement to Treatment with Opioids/Narcotics

____ **Patient Initial.** The first two pages of this form explained the risks, likely results, alternative choices, and problems that could result from taking Opioid/narcotic (pain relieving) drugs. If, after you have read and reviewed this form with your doctor, you do not believe that you fully understand the risks, likely results, other choices, and possible problems of opioid/narcotic (pain relieving) drugs, do not sign the form. Please have all your questions answered before signing.

I, _____, agree to obey the rules and follow the standards described in the first two pages of this form. I agree to submit to random and/or scheduled urine and/or blood screens for drugs and other medications. I understand that if I break this contract, my doctor reserves the right to stop prescribing narcotic/Opioid (pain relieving) drugs for me. I also agree that information about my pain medications may be shared with my other doctors. **I understand that only one pharmacy may be used for filling Opioid/narcotic prescriptions:**

Pharmacy Name _____ **Pharmacy #** _____

Because of my special health problems, these extra risks have also been explained to me:

I have these special health problems: **None** _____ **listed below:**

I have the following allergies: **None** _____ **listed below:**

I understand all the facts given to me in the first two (2) pages of this form. I give my consent to Dr. _____ and his/her associates to prescribe opioid/narcotic (pain relieving) drugs for me. My signature below certifies that my doctor has discussed all of the facts in this form with me, that I have had the chance to ask questions, and that all of my questions have been answered.

Signature of Patient or Responsible Party

Date and Time

Witness

Date and Time

Physician

I confirm with my signature that I have given the patient two pages of educational material and have discussed with the above-named patient the risks, likely results, other choices, and possible problems of opioid /narcotic medication. The patient has had the chance to ask questions, all questions have been answered, and he or she has expressed full understanding. Thus informed, the patient has asked that I prescribe opioid/narcotic medication for him or her.

Physician Signature

Date and Time