VALLEY PAIN CONSULTANTS
An Envision Physician Services Provider

Informed Consent and Controlled Substance Agreement for Treatment of Chronic Pain

The purpose of this agreement is to provide information to the patient regarding the use of controlled substances (opioid medications) for the treatment of chronic pain and to advise the patient of Valley Pain Consultants' expectations and requirements concerning prescriptions of controlled substances for their patients. The goal of any therapy is to assist the patient in achieving the best possible quality of life given the reality of the clinical condition being treated. Prescriptions of controlled substances may be part of the overall treatment plan in order to reduce pain and increase functional capacity.

Risks of opioid medications and other controlled substances include, but are not limited to, side effects such as constipation, rashes, itching, sexual dysfunction, sleeping abnormalities, sweating, and edema (swelling). This class of drugs may cause confusion, drowsiness, sedation (potentially severe), and the possibility of impaired cognitive function (mental status, thinking) and motor ability (movement and coordination). This may make it unsafe for you to drive a vehicle, operate hazardous equipment or do other dangerous activities. Under Arizona State Law, Title 284, Article 3, "It is unlawful for a person to drive or be in actual physical control of a vehicle in this state under the influence of intoxicating liquor, any drug, a vapor releasing substance containing a toxin, or any combination of liquor, drugs, or vapor releasing substances, if the person is impaired to the slightest." In Arizona this may be grounds for prosecution of a DUI offense. **Overuse or overdose of opioid medications and other Central Nervous System (CNS) depressants** can lead to profound sedation, respiratory depression (decreased breathing), coma and death.

Three issues that must be addressed prior to the initiation of therapy with a controlled substance are **physical dependence, addiction and tolerance. Physical dependence** is the body's response to chronic opiate therapy in which the body becomes used to the medication. With abrupt discontinuation of the medication, the patient may experience a **withdrawal syndrome**. This may include, but is not limited to, symptoms such as nervousness, irritability, insomnia, craving for the medication, rhinorrhea (watery discharge from nose), excessive tearing, sweating, abdominal cramping, nausea, vomiting, diarrhea and gooseflesh.

Addiction is not the same as physical dependence, but is the compulsive need for and use of a habit-forming substance characterized by tolerance and by well-defined physiological symptoms upon withdrawal. **Tolerance** may occur with chronic opioid therapy. This means that the therapeutic effects and side effects of the medication may decrease over time requiring adjustment of, or a change in, the medications. Some patients may even develop increased sensitivity to pain due to opiate medications (a condition known as *Opioid-Induced Hyperalgesia*) and may need to be weaned off of these medications as part of their treatment plan.

_____	_____	_____
Patient Name (print)	*Date*	*Patient Signature*

Please read each of the following statements carefully. After each statement, circle "T" if the statement is True, circle "F" if the statement is False.

1. I have tried other treatment options for my condition, however, they failed to effectively provide relief of my symptoms. ☐**T** ☐**F**

2. I do not have problems with substance abuse. ☐**T** ☐ **F**

3. I have never been involved with the sale, illegal possession, diversion or transport of controlled substances (opioids, sleeping pills, nerve pills or pain killers) or deception to obtain these substances. ☐**T** ☐ **F**

4. I will use only one pharmacy for filling all of my pain medications: ☐**T** ☐ **F**

   Pharmacy Name: _____ Phone: _____

   Cross Streets: _____

5. I will take opioid medications only as prescribed by the providers at Valley Pain Consultants. I will get prior approval from Valley Pain Consultants providers before taking any pain medications prescribed outside of a hospital/surgery center. ☐**T** ☐**F**

6. Under no circumstances will I allow other individuals to take my medications. ☐**T** ☐**F**

7. Under no circumstances will I take medication prescribed to another person. ☐**T** ☐**F**

8. I agree to allow Valley Pain Consultants to communicate with my referring physician and any other related health care professional (nurses, pharmacists, emergency services, etc.) regarding my use of controlled substances and the use or possible misuse or abuse of alcohol or other drugs. This permission shall expire only upon my written cancellation of this agreement. ☐**T** ☐**F**

9. I understand that my other health problems and the medications I use to treat them can increase the risks of driving while impaired. I agree to notify my doctor of any new medical conditions or drugs prescribed to me. ☐**T** ☐**F**

10. I agree to submit to unannounced random/directed pill counts or random/directed urine or blood tests in order to properly assess the effect of the opioids and my compliance. ☐**T** ☐**F**

11. **(If patient is male or a female of non-childbearing age, please circle N/A)** ☐***N/A***
    If a female of childbearing age, I certify that I am not pregnant and that I will use appropriate measures to prevent pregnancy during the course of treatment with opioids. ☐**T** ☐**F**

12. I understand no allowance will be made for loss of prescription drugs. Prescriptions will not be filled early for lost or stolen medications. ☐**T** ☐**F**

13. I will comply with the recommendation of a Valley Pain Consultants provider if he/she recommends a referral to a specialist to determine whether I am developing an addiction. ☐**T** ☐**F**

14. I understand that my doctor will not be available to prescribe medication during evenings and weekends. Valley Pain Consultants providers will not provide me with refills by phone, especially at night or on weekends. It is my responsibility to call my doctor at *least* **3 business days** in advance of running out of medications. ☐**T** ☐**F**

_____ _____ _____

Patient Name (print) *Date* *Patient Signature*

15. I understand that opioid pain medications can impair my judgment and ability to drive. This affects my safety and the safety of others and is also considered a crime. I agree not to drive when impairment is possible. ☐**T** ☐**F**

16. I understand that alcohol is detrimental to my treatment plan and can severely impair my judgment and ability to drive, which affects my safety and the safety of others and may be considered a crime. I agree not to misuse alcohol while using opioid medication and not to drive when impairment is possible. ☐**T** ☐**F**

17. I understand that Valley Pain Consultants policy prohibits the use of marijuana, **including prescription/medical marijuana**, while a patient is being prescribed controlled substances for the treatment of chronic pain. I understand that the use of marijuana, medical or otherwise, may result in the cessation of the treatment of pain with any controlled substance as per Valley Pain Consultants' policy which I have reviewed. ☐**T** ☐**F**

18. I understand treatment of my pain will be stopped if any of the following occur: ☐**T** ☐**F**

    - If my physician feels that opioid medications are not effective for my pain or that my functional activity is not improved.
    - I give, sell, or misuse the drugs.
    - I develop rapid tolerance or loss of effect from this treatment.
    - I develop side effects that are significant in the view of my doctor.
    - I obtain opioid medications from sources other than my physician.
    - I fail to comply with other parts of recommended treatment (i.e. physical therapy, behavioral management plan, etc.)
    - I consistently fail to keep my scheduled appointments.
    - I alter a prescription in any way.
    - I have significant or repeat urine drug screen/pill count violations.

19. I understand that my doctor will cease prescribing opioids to me, in them manner he/she deems most appropriate, in the event I do not follow the terms of this agreement or if my doctor believes that the opioids are harming me or not helping me. ☐**T** ☐**F**

20. I agree to allow Valley Pain Consultants' team members to assist in the destruction/ disposal of medications that I feel are no longer effective for my health condition. ☐**T** ☐**F**

21. I understand that chronic pain represents a complex problem that benefits from physical therapy, psychotherapy, and behavioral medicine strategies. I recognize that my active participation in the management of my pain is extremely important to improve my functioning and ability to cope. I agree to actively participate in all aspects of treatment. I agree to see other health care providers for evaluation and treatment of related and other medical conditions if determined necessary. ☐**T** ☐**F**

I certify that I have reviewed this agreement with the patient whose signature appears below, and that the **individual has knowingly and willingly signed this contract.**

Physician Signature: _____ Date: _____

I have read this document, understand it, and have had all questions regarding risks and conditions of the contract answered satisfactorily and I agree to all conditions of this opioid agreement. I agree to the use of opioids to help control my pain, and I understand that my treatment with opioids will be carried out in accordance with the conditions stated above.

_____	_____	_____
Patient Name (print)	*Date*	*Patient Signature*