Envision
PHYSICIAN SERVICES

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 your healthcare provider 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. Many states have laws prohibiting the operation of a motor vehicle while impaired and you may be subject to criminal or other prosecution under state law if you choose to operate such equipment while impaired.

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.

Please read each of the following statements carefully.

1. I have tried other treatment options for my condition, without effective relief of my symptoms.

2. 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. I also understand that these actions may be criminal offenses.

3. I will take opioid medications only as prescribed by my healthcare providers and I will get prior approval from this pain management center before taking any pain medications prescribed outside of a hospital/surgery center.

4. Under no circumstances will I allow other individuals to take my medications.

5. Under no circumstances will I take medication prescribed to another person.

6. I agree to allow this pain treatment center to communicate with my referring physician and any other related health care professional 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.

7. I understand that the controlled substances being prescribed to me may cause impairment due to my other health problems. I agree to notify my doctor of any new medical conditions or drugs prescribed to me.

8. I agree to submit to unannounced random pill counts, urine, saliva or blood tests in order to properly assess my compliance.

9. 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.

10. I agree to safeguard my medications in a secure location such as a lock box so that others will not be able to access these medications.

11. I understand prescriptions will not be filled early for lost or stolen medications.

12. I understand that the controlled substances being prescribed may cause psychological dependence or addiction. I will comply with any recommendation to be evaluated/treated by a specialist for any potential addiction concerns.

13. I understand that these controlled substances may cause physical dependence as well.

14. I understand that my doctor will not be available to prescribe medication during evenings and weekends. It is my responsibility to call my doctor at *least* **3 business days** in advance of running out of medications.

15. I will comply with the recommendation of my healthcare providers if he/she recommends a referral to a specialist to determine whether I am developing an addiction.

16. I understand that opioid pain medications can impair my judgment and ability to drive or Operate heavy machinery. I agree to use caution when taking these medications and to avoid driving or operating heavy machinery if I am impaired.

17. I understand that alcohol may potentiate the effects and duration of my controlled substance medications and I have been advised to avoid using alcohol when taking these medications.

18. I understand that marijuana, **including prescription/medical marijuana**, may interact with the controlled substances I am being prescribed for chronic pain and cause increased impairment. Use of marijuana may necessitate dosing changes in the controlled substance medications that this clinic is prescribing

19. I understand treatment of my pain will be stopped if any of the following occur:

    - 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.
    - I use any illegal controlled substance
    - I do not maintain appropriate behavior at all times with my clinicians and support staff

20. I understand that my doctor will cease prescribing opioids to me, in the 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.

21. I agree to allow this pain treatment center's team members to assist in the destruction/ disposal of medications that I feel are no longer effective for my health condition.

22. 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.

I have read this document, understand it, and have had all questions regarding risks and conditions of the contract answered satisfactorily. I hereby 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*