CONSULTANTS IN PAIN MANAGEMENT

Patient name:_____ **DOB:**_____ **Today's Date:** _____

Consent for Chronic Opioid Therapy

Consultants in Pain Management PC, is prescribing opioid medication, sometimes called narcotic analgesics, to me for the treatment of my chronic pain. This decision was made because my pain problem is serious and/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 and possibility that the medicine will not provide complete pain relief.

I am aware of other types of treatment that are used for pain management that do not involve the use of opioids. Other approaches that are sometimes used to help manage pain include acupuncture, chiropractic care and exercise.

I will tell my provider about all other medicines and treatments that I am receiving, from all of my providers.

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: operating heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for his or herself.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medication is relatively low. 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 agree to bring a current updated medication list to every office visit. I also agree to bring all my medication written by CPM to each appointment.

I understand that physical dependence is a normal, expected result of using these medicines for a long period of time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine is markedly decreased or stopped, I will experience a withdrawal syndrome. This means I may have any or all of the following symptoms: runny nose, yawning, dilated or enlarged pupils, goose bumps, abdominal pain, cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

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 occurred and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my provider to choose another form of treatment

Consent for Chronic Opioid Therapy

(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 provider 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 provider 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 have read this form or have had it read to me. I understand all of it. I have had a 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**

_____ _____

Provider Signature **Date**