

OPIOID THERAPY

The long-term use of opioid therapy (narcotic analgesics) is somewhat controversial because of uncertainty regarding the extent to which this treatment actually improves the quality of life of those receiving it. There is the potential risk of an addictive disorder developing or of relapse occurring in a person with a prior addictive disorder. The extent of this risk is not certain. These drugs all have potential for abuse or diversion and, accordingly, rather strict accountability is necessary when use is prolonged.

Patient's
Initials

_____ Details of the treatment including the anticipated benefits and material risks have been explained to me in terms I understand.

_____ Alternative methods and therapies, their benefits, material risks and disadvantages, have been explained to me.

_____ I understand and accept that the most likely material risks and complications of opioid therapy have been discussed with me and may include but are not limited to:

- *addiction or psychological dependence; that is, an abnormal psychological aberration of compulsively craving the opioid to the point of becoming a danger to self and/or others*
- *breathing too slowly; overdose can lead to respiratory arrest and death*
- *children born to mothers who have been prescribed opioids are likely to be born with physical dependence on the opioid*
- *confusion or other alteration in thinking and alertness*
- *decreased appetite*
- *increased sleepiness or drowsiness*
- *nausea*
- *physical dependence; that is, stopping the medication abruptly may lead to withdrawal syndrome characterized by one or more of the following: runny nose, anxiety, diarrhea, abdominal cramping*
- *problems with coordination and balance*
- *urinary retention*
- *constipation*

_____ I understand and accept that there are complications, including the remote risk of death or serious disability.

_____ I attest that I do not have current problems with substance abuse, nor am I involved in the sale, illegal possession, or transport of controlled substances (narcotics, sedatives, anti-anxiety medications).

_____ I will abstain from taking any medications (prescription, nonprescription or recreational) that I have not disclosed to my physician.

_____ I understand and accept that random urine or blood drug screens may be requested at any time.

_____ I understand that all narcotics must come from the designated physician or, during his/her absence, from the physician covering call for that physician.

_____ I understand that all narcotics must be obtained at the same pharmacy.

_____ I understand and accept that my physician is at complete liberty to discuss all diagnostic and treatment details with pharmacists at the dispensing pharmacy for purposes of maintaining accountability.

_____ I understand that refills will only be offered during regular business hours, never on weekends or holidays. *There will be no exceptions for refills.*

_____ I understand that if faced with an acute situation requiring drug therapy after hours, my physician will only prescribe a sufficient amount to cover the time until an office visit may occur.

_____ I understand that prescriptions that are lost, stolen, accidentally disposed of, or consumed before the appropriate date, will not be refilled.

Continued

- _____ I will notify my physician of any acute need (e.g., dental procedures, surgery) that may require a temporary change in my opioid dose.
- _____ I understand that all confidentiality in regard to controlled prescriptions is waived in the event that legal authorities request information concerning inappropriate or unlawful use of controlled substances obtained through _____ and any other medical professional.
(entity name)
- _____ I understand that I may be referred to a specialist if my physician is concerned about inappropriate use of medication(s), substance abuse, or psychological dependence.
- _____ I understand that failure to adhere to the conditions established in this agreement will result in a permanent termination from all services provided by Dr. _____.
- _____ The doctor has answered all of my questions regarding this treatment.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct _____, M.D. to provide opioid therapy.

I, _____, understand that in order to initiate and/or continue opioid therapy, I
(patient name)
must agree to and follow the conditions set forth by my physician.

Patient or Legal Representative Signature/Date/Time	Relationship to Patient
Print Patient or Legal Representative Name	Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative *(circle one)* fully understands what I have explained.

Physician Signature/Date/Time	
_____ copy given to patient initial	_____ original placed in chart initial