



Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

## Opioid Treatment Agreement

Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling, or other therapies or treatment. Vocational counseling may be provided to assist in your return to work effort. Opioids are deemed the last resort and are only prescribed while adhering to other non-opioid treatment modalities.

I, \_\_\_\_\_, understand that compliance with the following guidelines is important in continuing pain treatment at the Painless Center, LLC. Furthermore, I understand that I have the following responsibilities:

1. I will take medications only at the dose and frequency prescribed
2. I will not increase or change medications without the approval of **Dr. Chiu**
3. I will actively participate in non-opioid treatment and in any program designed to improve function (including social, physical, psychological, daily or work activities and interventional pain procedures)
4. I will not request opioids or any other pain medicine from physicians other than from a **Dr. Chiu / The Painless Center, LLC**. The doctor will approve and be informed of all other mind and mood altering drugs
5. I will inform the doctor of all other medications that I am taking
6. I will obtain all medications from one pharmacy, when possible known to this office, with full consent to talk with the pharmacist given by signing this agreement
7. I will protect my prescriptions and medications. Only one lost prescription or medication will be replaced in a single calendar year. I will keep all medications from children and store medications at a locked location only accessible by me
8. I agree to participate in psychiatric or psychological assessments, if necessary
9. If I exhibit signs of belligerence and / or signs of addiction noticeable by the office staff or providers at **The Painless Center, LLC**, I understand that I will be formally discharged and will no longer seek treatment at **The Painless Center, LLC**.
10. I understand that in the event of an emergency, the doctor's office should be contacted and the problem will be discussed with the emergency room or other treating physician. I am responsible for signing consent to request records transfer to this doctor. No more than 3 days of medications may be prescribed by the emergency room or other physician without Dr. Chiu's approval.
11. I understand that I will consent to random drug screenings. A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.



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12. I will reschedule or cancel my set appointment(s) a minimum of 24 hours prior to the appointment.
13. I understand that **Dr. Chiu** may stop prescribing opioids or change the treatment plan due to any of the following:
- I do not show any improvement in pain from opioids or my physical activity has not improved
  - My behavior is inconsistent with the responsibilities outlined above
  - I give, sell or misuse the opioid medications
  - I develop rapid tolerance or loss of improvement from the treatment
  - I obtain opioids from outside of **The Painless Center, LLC**
  - I refuse to cooperate when asked to be drug screened
  - If an addiction problem is identified as a result of prescribed treatment or any other addictive substance
  - If I am unable to keep follow-up appointments

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Date: \_\_\_\_\_

If I have an addiction problem, I will not use illegal drugs, street drugs, or alcohol and will inform my doctor at **The Painless Center, LLC**. This doctor may ask me to follow through with a program to address this issue. Such programs include, but are not limited to, the following:

- A 12-step program
- Securing a sponsor
- Individual counseling
- Inpatient or outpatient treatment including Suboxone or infusion treatments

### Risks

Safety risks while working under the influence of opioids:

Please be aware of potential side effects associated with opioids such as:

- Decreased reaction time
- Clouded judgment
- Drowsiness
- Tolerance

\*Please be advised that driving and / or operating heavy machinery is **not** recommended when under the influence of opioids.

Your provider will instruct you on the side effects of opioid use at your regular clinical appointment. You will be prescribed an intra muscular naloxone (opioid reversal) injection to use in the case of opioid overdose as per New Jersey regulation. The provider will answer any questions regarding the proper usage of the intramuscular naloxone, and you are responsible for obtaining it at your pharmacy.



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**Side Effects**

- Confusion or other change in thinking abilities
- Nausea
- Constipation
- Problems with coordination or balance
- Sleepiness or drowsiness
- Aggravation or depression
- Breathing too slowly — overdose can stop your breathing and lead to death
- Vomiting Dry mouth

**These side effects may be made worse if you mix opioids with other drugs, including alcohol.**

**Recommendations to Manage Your Medications:**

Keep a diary of the pain medications you are taking, the medication dose, time of day you are taking them, their effectiveness, and any side-effects you may be having.

Purchase a medication box / container from your pharmacy. These will allow you to organize your medications into times of day and days of the week. This will make it easier to remember when to take your medications.

Carry only the amount of medicine you need when leaving home so there is less risk of losing your medications.

I have read this document, understood its contents, and have had all my questions answered satisfactorily. I consent to the use of opioids to help control my pain, and I understand that my treatment with opioids will be carried out as described above.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date