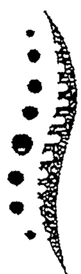


SPINE & PAIN

INSTITUTE OF FLORIDA

P E R S O N A L I Z E D C A R E

NEW PATIENT HISTORY FORM

(This form must be completed prior to being seen)

Name: ______________________________ DOB: ____________ Date: _____________

Referring Physician: ________________________ Primary Physician:______________________

PRIMARY COMPLAINT

When did your pain start? .

____

Under what circumstances did your pain begin? (Please select the appropriate indicator listed below)

_______ At work, but NOT an accident

_______ Accident at work, date _________

_______Following surgery, date_________

_______ Motor vehicle accident, date__________

_______Following illness

_______ Accident at home

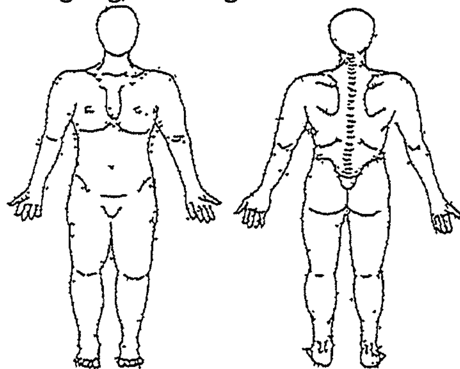
_______Pain began with no known cause

____

Other_______________________________

Where is the location of your pain?

Please shade the painful areas on the diagram below xxxx for most severe pain 000 for less severe pain for tingling/burning



NUMERIC PAIN SCALE

Please circle the number that best describes the amount of pain you feel right now.

No pain 0 1 2 3 4 5 6 7 8 9 10 worst pain imaginable

What is the highest number that your pain goes to? ________

What is the lowest number that your pain goes to? ________

What best describes your pain? (Please circle all that apply)
Burning stabbing shooting aching dull electrical deep vague sharp
constant intermittent daily other
(describe)____

Do you have any numbness? Yes No If yes, where?________________________
Do you have any weakness? Yes No If yes, where?________________________

What makes your pain worse? (please circle all that apply)

exercise bending forward bending backwards walking cold stress

climbing stairs lifting sitting standing heat

work driving cough/sneeze sexual activity light touch
other: (describe): ____

What relieves your pain? (please circle all that apply)
lying down sitting standing walking

physical therapy exercise ice heat

medications bath/shower meditation relaxation
Other (describe):____

Have you ever been treated at another pain management center or program? Yes No
If yes, where? ______________________________ When? ____________________

MEDICATIONS

Do you take any blood thinning medication? Yes No If yes, what? ____________________
(This is not an all-inclusive list but examples of some anticoagulants include Coumadin, Plavix, Aggranox, or others).

List all medications that you are taking now. (Include over the counter, herbal, vitamins, and other supplemental medications) If you need more room to write medications, please use the back of this page.

Medication	Dose (mg)	How often? times/day)	What is this medication for?	Date started	Prescribing Doctor

List all other pain medications you have tried in the past and why you stopped taking them:

____

____

ALLERGIES

Please list any known drug, food, or environmental allergies and indicate the adverse effect/reaction:

____

MEDICAL HISTORY

(please circle all that apply)

Cardiovascular: Chest pain Heart attack Heart disease Heart rhythm disturbances Blood thinners High blood pressure Low blood pressure Venous insufficiency Arterial insufficiency

Respiratory: Asthma Emphysema Chronic bronchitis COPD Chronic pneumonia Pleurisy Embolism Abnormal chest x-ray Positive TB test Frequent colds/sore throat

Endocrine: Diabetes Insulin Obesity Hypothyroid Hyperthyroid Grave's disease Hashimoto's hypothyroidism

Gastrointestinal: Colitis Irritable bowel syndrome Gastritis Hiatal hernia Acid reflux/GERD Ulcers Polyps Bowel problems Liver disease Crohn's disease Gallbladder problems Special diet Pancreatitis

Genitourinary: Kidney problems Sexual dysfunction Sexually transmitted disease Prostate disease Chronic urinary tract infection Bladder problems Hepatitis A,B,C

Hematologic: Anticoagulation Easy bruising Blood clots Bleeding disorders Anemia

Neurological: Memory problems Seizures Stroke Movement disorder Muscular dystrophy Neuropathy Migraine/Headaches Epilepsy

Psychological: Nervous breakdown Depression Anxiety Panic disorder Psychosis Alcohol/drug abuse

Musculoskeletal: Fibromyalgia Rheumatoid arthritis Osteoarthritis Osteoporosis Back problems Neck problems

Allergic/Immunological: Autoimmune disorder MS Lupus, Sjogren's Raynaud's syndrome Immune deficiency HIV

General: Medical equipment Cane Walker Wheelchair Hospital bed Oxygen at ______LPM

Miscellaneous: Glaucoma Cataracts Visual problems Hearing loss Chronic skin disorder Pregnancy

Cancer: Site: ________________________________ Diagnosis Date: ______________ Chemotherapy Radiation

SURGICAL HISTORY

(Please list all surgeries)

DATE	SURGERY	DOCTOR

FAMILY MEDICAL HISTORY

Please list any major medical conditions your family member has had (heart attack, stroke, high blood pressure, migraines, diabetes, cancer):

Father: Alive/Deceased____

Mother: Alive/Deceased____

Sister: Alive/Deceased____

Brother: Alive/Deceased____

SOCIAL HISTORY

Smoking status: Current _____ packs/day for ______ years Former: quit ______ Never

Alcohol intake: _______ times/ week month year Ever drink more than 6 drinks in 1 day? Yes No

PSYCHOSOCIAL HISTORY

Highest level of education? ________________________________Are you going to school now? Yes No

Are you able to care for yourself? Yes No If no, who helps you?_______________________________________

Have you fallen lately? Yes No When? __________________Do you use any assistive device at home? (walker, cane, etc;)____

What exercise or recreational activities do you enjoy?____

How often do you exercise or do the above activities?____

Do you feel safe in your home? Yes No If not, why?____

Have there been any other stressful life experiences recently? Yes No If so, explain:____________________

____

Have you ever had thoughts of suicide or harming yourself? Yes No If yes, did you seek help? Yes No

Have you ever had thoughts of harming someone else? Yes No If yes, who?___________________________

Have you been under the care of a mental health professional? Yes No If yes, who?____________________

Have you received treatment for alcohol or substance (legal/illegal) abuse? Yes No

If yes, when? ________________

MEDICAL TESTING

(Select the medical tests below that have been done to evaluate your pain)

	Date (approximate)	Result (If known)
X-ray	____________	____________________
CT scan	____________	____________________
Myelogram	____________	____________________
MRI	____________	____________________
Discogram	____________	____________________
Bone scan	____________	____________________
EMG	____________	____________________

MISCELLANEOUS

Are you, or have you ever been, involved with any of the following?

Disability:

________Not receiving or seeking disability

________Not receiving but seeking or planning to seek disability

________Receiving disability

Litigation/lawsuit(s):

_______No & not intending pain-related litigation/lawsuit

_______Currently in pain related litigation/lawsuit.

________Past litigation/lawsuit or legal involvements related to pain condition

Motor Vehicle Accidents:

_____Pain not related to motor vehicle accident

_____Pain related to motor vehicle accident and settlement pending

_____Pain related to motor vehicle accident but no settlement pending or necessary

Do you have any other litigation or lawsuits ongoing, pending, planned, or under consideration?

_____Yes ____No (If so, please explain) ________________________________

REVIEW OF SYSTEMS

(Please circle any of the listed symptoms that are current problems for you)

Constitutional: fever chills weight loss or gain fatigue

Eyes: double vision blurry vision need for glasses injury or surgery

Ear, Nose, Throat: sinusitis hearing loss ringing in ears sores voice change swelling

Cardiovascular: palpitations leg swelling heart-attack chest pain high blood pressure

Respiratory: shortness of breath asthma cough spitting up blood wheezing

Gastrointestinal: loss of appetite nausea vomiting blood in stools

Genitourinary: frequent/painful urination incontinence urinary tract/bladder infections irregular menses

Musculoskeletal: Joint pain or stiffness weakness injury or surgery swelling spasm

Skin/Breast: rashes ulcers nail changes breast pain breast lump breast discharge

Neurological: stroke or TIA headaches dizziness seizures loss of balance

Psychological: memory loss depression insomnia anxiety nervousness

Endocrine: diabetes thyroid problems excessive thirst or urination

Hematologic: bleeding or bruising tendency phlebitis DVT blood clots transfusion

PAIN MANAGEMENT GOALS & EXPECTATIONS

What do you expect from our pain program? (select the ONE best answer)

_______A diagnosis (to help find the cause of pain)

_______Help in coping with the pain

_______A reduction in pain

_______A cure

_______No expectations

_______Do not know what to expect

PAST TREATMENTS

(Please select the treatments you have received for your pain problem, and what was the result?)

Indicate Pain Therapies	Tried	Not Tried	Improved	No change	Worse	Comments
Drug Detoxification						
Epidural steroid injections						
Facet joint Injections						
Trigger point injections						
Nerve (lumbar sympathetic, stellate ganglion, etc.) blocks						
Spinal cord stimulation						
Medication pump						
Radiation therapy						
Physical therapy						
Exercise						
Manipulations/Mobilizations						
Traction Exercise/Aerobic conditioning						
Passive (heat, ice, gentle massage, ultrasound)						
Aqua/water/pool therapy						
Trigger point therapy/deep tissue massage/acupressure						
Occupational therapy						
Acupuncture						
Chiropractic						
Prosthetics/Orthotics(e.g. braces, supports, etc.)						
Electric stimulation (TENS)						
Biofeedback/relaxation						
Yoga						
Hypnosis						
Other						

Patient Name: ______________________________ Date: ____/_____/______

Please answer each question as honestly as possible by putting the corresponding number in the box to the right (ie, if "Seldom" write "1", if "Sometimes" write "2", etc). There are no right or wrong answers.

SCORE	COLOR	Initials of Reviewer

SOAPP®-R	Never	Seldom	Sometimes	Often	Very Often
1. How often do you have mood swings?	0	1	2	3	4
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you can't handle them?					
5. How often is there tension in your home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medications from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					
Has any relative had a problem with: **(Please circle Y/N for each item below)** Alcohol: Y/N Addiction: Y/N Mental Illness: Y/N					

Green = less than 9	*Yellow = 10-21*	*Red = 22 and over*

Please include any additional information you wish about the above answers. Thank you.
STOP: Hand first 6 pages of packet to front desk if filling out paperwork in office

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SPINE & PAIN
INSTITUTE OF FLORIDA

New Patient Demographics

Date: ______________________________ Home Phone: __________________________

Social Security Number: _______________ Cell Phone: ____________________________

Email: _______________________________ Work Phone: __________________________

Pharmacy Name & Location: ____

PATIENT:

Name (Last, First, MI): ____

Street Address: ____

City: ________________________________ State: _______________ Zip Code: _____________

Gender: M / F Age: __________ Birthdate: ____________ Height: ____'____" Weight: ______Lbs.

Marital Status: Single Married Widowed Separated Divorced

Spouse's Name: ____________________________ Birthdate: __________________________

Spouse's phone number: _____________________ Spouse's SSN: ______________________

EMPLOYMENT:

Employed Disabled Retired Full-time Student Part-time Student Unemployed

Patient Employer: ____

Business Address & Phone: ____

INSURANCE:

Do you have medical insurance? Yes No

PRIMARY INSURANCE NAME: ____

ID #: _____________________________ Group #: _______________ Subscriber: _______________

SECONDARY INSURANCE NAME: ____

ID #: _____________________________ Group #: _______________ Subscriber: _______________

Workers Compensation: Yes No

Claim #: _________________________________ Adjuster: _____________________________

Phone #: ____________________ Fax #: _____________________ Date of Injury: _______________

Claims Mailing Address: ____

SPINE & PAIN
INSTITUTE OF FLORIDA
PERSONALIZED CARE

Consent to Medical Treatment:

Spine & Pain Institute of Florida (SPIF) maintains personnel and facilities in order to assist my physicians in providing me with medical care, and I authorize SPIF providers and personnel to perform on me the care ordered by my physicians. I consent to receive services by telemedicine (using Interactive audio, video, or data communications to carry out consultations, evaluations, screenings, diagnosis, treatment, monitoring or other communications benefiting a patient) if appropriate for my condition, and I understand the risks, benefits and alternatives of doing so. I choose to receive services even if my insurance plan may not cover or continue to cover specific services, including the specific services rendered during the admission. I understand that I have the right to be informed by my providers of the nature and purpose of any proposed operation or procedure and any available alternative methods of treatment together with an explanation of the risks associated with each of them. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to the recognized standards of medical practice, and I acknowledge that SPIF and its personnel are not responsible for providing me this information. I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of examinations and/or treatments provided by SPIF.

Consent to Recording or Filming.

I authorize SPIF, the attending physician, or other SPIF authorized persons to record, photograph or film me for treatment, quality improvement or education purposes. Such recording, filming or photographs will be released only as permitted by law or authorized by me.

Assignment of Insurance Benefits. Patient financial Responsibility and Credit Report Authorizations:

I guarantee payment of all charges made for or on account of the patient. I assign my right and my insurance benefit payments or other payment sources directly to SPIF and/or the physicians providing services in conjunction with SPIF. This assignment includes, but is not limited to, radiology reading, pathology services, emergency room visits or EKG readings. I understand I will receive separate bills for certain SPIF and physician services. I understand I am financially responsible to SPIF and physicians for charges not covered by this insurance assignment. I further understand SPIF can obtain my credit report for collection purposes and I am responsible for any collections, attorney fees and costs. I have provided all Medicare information and insurance cards to SPIF. I agree that in the event benefits paid under this assignment or any other amounts paid by me/us on my/our behalf exceeds the amount due the SPIF, my physicians, or those entitles for services in connection with this treatment, and such excess amount may be applied to any other indebtedness that I, my spouse, or any child for whom I am financially responsibly may have with the SPIF or any other facility entity related to SPIF.

Authorization to Disclose Information and Privacy Act:

I authorize SPF, and its affiliates to use or disclose my protected health information for the purposes of treatment, payment or healthcare operations. This consent shall cover any of my protected health information that SPIF may maintain or receive. I authorize the release of medical and related information about my treatment to the Professional Standards Review Organization responsible for reviewing the medical care furnished to me. This authorization will expire six years from the date shown below; however I reserve the right to revoke this authorization at any time by contacting the Corporate Privacy Officer at (828)221-0121. I understand I have the right to review the Notice of Privacy Practices before signing this consent. I further understand that the Notice of Privacy Practices provides a more complete explanation of the uses and disclosures of my protected health Information.

Authorization to Release Medical Information:

I authorize the SPIF and my physicians to disclose any medical information related to my services or treatment to my insurance company, governmental or charitable agencies and their agents, my employer and professional review organizations with whom I may have insurance coverage or who may be assisting in the payment of my bill and my medical care. I also authorize SPIF and my physicians to release any medical information to any licensed physician or medical facility to which I may be referred or transferred for further medical care. In addition, I authorize SPIF and my physicians to release any medical information necessary to prove the SPIF's damages in any legal proceeding brought about to enforce any unpaid balance on any of my accounts. This authorization will expire two (2) years from the date shown below, and I understand that I or my legal representative may revoke this authorization at any time, unless legal action has already been taken, or in the event of my death, the release of medical information is necessary to verify any charges incurred by me.

Authorization to Release Medicare and Medicaid Information:

I certify that the information provided by me in applying for payment under Titles XVIII and/or XIX of the Social Security Act is correct. I understand that health care services paid for under Medicare, Medicaid and Maternal and Child Health programs are subject to review by professional organizations, which may recommend denial of payment if my medical condition does not warrant continued SPIF care. I authorize the Financial Counseling Wellness staff of the SPIF to assist me in the processing of any benefits, application, including Medical Assistance, Aid to Families with dependent Children, or Special Assistance, initiated for

SPINE & PAIN

INSTITUTE OF FLORIDA

PERSONALIZED CARE

the patient within six months of the date of this authorization. The Financial Counselor may have access to and copy any records or information to which I would be entitled. I authorize and direct the County Department of Social Services to provide such information to the Financial Counselor orally via telephone. I authorize and consent to referral to the County for benefits by use of any appropriate referral form. The doctrine of informed consent has been explained to me, I acknowledge that this consent is voluntary and that it may be revoked by me at any time except to the extent that action has already been taken in reliance on it. Unless otherwise revoked, this consent shall be valid for one year from the date of authorization, or until final determination of any benefits application as described above, whichever is later.

For Underinsured Patients or Uninsured Patients:

I authorize SPIF and its affiliates, to use or disclose my protected healthcare information for the purpose of helping me find a healthcare provider and/or locate a payment source for my visit.

Release of Responsibility/Liability For Valuables:

I understand that SPIF has a policy for safekeeping of patient valuables requiring all money, credit cards and/or items of value including jewelry to be given to a family member to hold or leave at home. If I choose not to deposit such items of value with my family member, I absolve SPIF from responsibility for their loss, damage or disappearance.

Payment Guaranty: (Patient and/or responsible party/parties) agree to pay all charges for services rendered by SPIF and my physicians or other providers during treatment related to services provided by SPIF. This guaranty includes charges not covered by my insurance regardless of the reason insurance coverage is denied. I agree to pay the reasonable cost of the attorney services in addition to the unpaid charges. I consent and authorize SPIF and its agents or subcontractors to contact outside sources for the purpose related to my account, including evaluating and assessing my credit worthiness, my charity eligibility and the viability of collecting any amounts due for treatments I receive, whether at this time or on subsequent visits. I understand and agree that SPJF may assign my accounts as it deems necessary for the purposes of collecting any amounts I owe, including to collection agencies and attorneys. I consent and authorize SPIF and third-party agents of SPIF to contact me at any telephone associated with me, including a wireless number, and to use pre-recorded and/or an automatic dialing service in connection with any communication made to me or related to my account

I affirm that my signature on this form indicates that I have disclosed any and all current insurance coverage/s that may pay for this visit. Further, any failure on my part to identify my insurance/s may result in additional charges for which I will be responsible. My signature also indicates that if I have no insurance coverage I will cooperate and participate in any efforts to help me qualify for any applicable coverage. Failure to do so may render me ineligible for any financial assistance discounts.

I have read the request and authorization in Its entirety and agree to be bound by all the terms and conditions herein. Witness my (our) hand(s) and seal(s) below.

____________________________ ____________________________

Patient | Responsible Party(ies)

____________________________ ____________________________

Witness | Relationship to Patient

____Spouse _____Parent _____Other (Specify)___________

****

I have been provided access to SPIF Notice of Privacy Practices

____________________________ ______________ __________

Patient (or authorized representative) | Date | Time

Patient unable/unwilling to sign _________ Reason ____

SPIF Representative ___________________________Date/Time _________________

SPINE & PAIN
INSTITUTE OF FLORIDA

MEDICAL RECORDS RELEASE FORM

Patient Name:____________________________Date of Birth:______________________
Phone Number:____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that, by initialing this form, I am specifically authorizing that release of this information.
Initials: Date:

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Name: Spine & Pain Institute of Florida
Street: 1417 Lakeland Hills Boulevard Suite 201 City: Lakeland State: FL Zip: 33805

I do give permission for these records to be faxed to the above entity.

Please forward:

_____Office Visits _____Initial History and Physical _____MRI Reports

_____Lab Reports _____Correspondence _____Insurance Information

_____Other (please specify)____

Patient Signature:____________________________________Date:______________

SPINE & PAIN
INSTITUTE OF FLORIDA
PERSONALIZEDCARE

PATIENT SELF-DETERMINATION QUESTIONNAIRE YOUR RIGHT TO DECIDE

While you cannot remove all uncertainty about your future health care needs, having an ADVANCE DIRECTIVE in place can give you the peace of mind that comes from making your wishes known in advance.

- Declaration to Decline Life Prolonging Procedures
  ☐ I have ☐ I have NOT made a Living Will
- Health Care Surrogate
  ☐ I have ☐ I have NOT designated a Health Care Surrogate
- Durable Power of Attorney
  ☐ I have ☐ I have NOT appointed a Durable Power of Attorney for Health Care Decisions

If you have a living will and/or an assigned health care surrogate we will gladly make a copy of your documents and place it in your chart.

PATIENT PRIVACY QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name: ______________________ Name: ______________________

Address: ______________________ Address: ______________________

Phone Number: ______________________ Phone Number: ______________________

Relationship: ______________________ Relationship: ______________________

Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name: ______________________ Phone #: ______________________
Name: ______________________ Phone #: ______________________

III. Please indicate your understanding that all correspondence from our office will be sent in a sealed envelope marked "CONFIDENTIAL": ☐ Check here to indicate that this statement was read.

IV. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? Yes No

V. Please print the phone number where you want to receive calls about your appointments: ______________
☐ I am fully aware that a cell phone is not a secure and private line.

______________________ ______________________
PLEASE *PRINT* PATIENT NAME DATE OF BIRTH

______________________ ______________________
LEGAL REPRESENTATIVE RELATIONSHIP TO PATIENT

______________________ ______________________
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE TODAY'S DATE

SPINE& PAIN
INSTITUTE OF FLORIDA
PERSONALIZEDCARE

PHYSICIAN/PATIENT INFORMED CONSENT AND AGREEMENT FOR LONG-TERM OPIOID/NARCOTIC THERAPY FOR TREATMENT OF CHRONIC PAIN

PATIENT NAME: ______________________________ DOB: ______________

You have agreed to or may potentially receive opioid/narcotic therapy for the treatment of chronic pain. You understand that these drugs are very useful but have a potential for misuse and are therefore closely controlled by local, state and federal governments. The goal of this treatment is to: (a) reduce your pain; and (b) improve your level of function in performing your activities of daily living. Our goal is to not initiate or continue opioid therapy whenever possible, but sometimes this may be warranted for more effective pain management.
Alternative therapies and medications have been explained and offered to you. You have chosen opioid/narcotic therapy as one component of treatment.
The use of cigarettes demonstrates a dependence on nicotine. This complicates opioid therapy. If you are a smoker, you have agreed to a smoking cessation program.
You must be aware of the potential side effects and risks of these medications. They are explained below. If you have any questions or concerns during the course of your treatment, you should contact your physician.

SIDE EFFECTS

Side effects are normal physical reactions to medications. Common side effects of opioids/narcotics include mood changes, drowsiness, dizziness, constipation, nausea, and confusion. Many of these side effects will resolve over days or weeks. Constipation often persists and may require additional medication. If other side effects persist, different opioids may be tried or they may be discontinued. You should NOT:

a. operate a vehicle or machinery if the medication makes you drowsy;
b. consume ANY alcohol while taking opioids/narcotics; or
c. take any other non-prescribed sedative medication while taking opioids/narcotics.

The effects of alcohol and sedatives are additive with those of opioids/narcotics. If you take these substances in combination with opioids/narcotics, a dangerous situation could result, such as coma, organ damage or even death. Driving while taking opioids for chronic pain is considered medically acceptable as long as you do not have side effects such as sedation or altered mental status. These side effects usually do not occur while taking opioids/narcotics chronically. However, it is possible that you could be considered DUI if stopped by law enforcement while driving.
Opioids have also been known to cause decreased sexual function and libido. This is due to their effects on suppression of certain hormones such as testosterone and DHEA which can cause these side effects. Your hormone levels can be monitored during your treatment.
Constipation is a well-known side effect of opioid therapy and can usually be treated with stool softeners or gentle laxatives. Constipation is a side effect that usually does not go away and requires treatment.

PATIENT'S INITIALS:______

PATIENT NAME: ______________________________ DOB: ______________

RISKS:

DEPENDENCE

Physical dependence is an expected side effect of long-term opioid/narcotic therapy. This means that if you take opioids/narcotics continuously, and then stop them abruptly, you will experience a withdrawal syndrome. This syndrome often includes sweating, diarrhea, irritability, sleeplessness, runny nose, tearing, muscle and bone aching, gooseflesh, and dilated pupils. Withdrawal can be life threatening. To prevent these symptoms, the opioid/narcotics should be taken regularly or, if discontinued, reduced gradually under the supervision of your physician.

TOLERANCE

Tolerance to the pain-relieving effect of opioids/narcotics is possible with continued use. This means that more medication is required to achieve the same level of pain control experienced when the opioid/narcotic therapy was initiated. This may occur even though there has been no change in your underlying painful condition. When tolerance does occur, sometimes it requires tapering or discontinuation of the opioid/narcotic. Sometimes tolerance can be treated by substituting a different opioid/narcotic. When initiated, doses of medications must be adjusted to achieve a therapeutic, pain-relieving effect upward adjustments during this period are not viewed as tolerance.

INCREASED PAIN (Hyperalgesia)

The long-term effects of opioids/narcotics on the body's own pain-fighting systems are unknown. Some evidence suggests that opioids/narcotics may interfere with pain modulation, resulting in an increased sensitivity to pain. Sometimes individuals who have been on long-term opioids/narcotics, but who continue to have pain, actually note decreased pain after several weeks off the medications.

ADDICTION

Addiction is a primary, chronic, neurological disease, with genetic, psychosocial, and environmental factors influencing the development and manifestations. It is characterized by behaviors that include one or more of the following:

- Impaired control over drug use;
- Compulsive use;
- Continued use despite harm; and/or
- Craving.

Most patients with chronic pain who use long-term opioids/narcotics are able to take medications on a scheduled basis as prescribed, do not seek other drugs when their pain is controlled, and experience improvement in their quality of life as the result of opioid therapy. Therefore, they are NOT addicted. Physical dependence is NOT the same as addiction.

RISK TO UNBORN CHILDREN:

Children born to women who are taking opioids/narcotics on a regular basis will likely be physically dependent at birth. Women of childbearing age should maintain safe and effective birth control while on opioid/narcotic therapy. Should you become pregnant, immediately contact your physician and the medication will be tapered and stopped.

PATIENT'S INITIALS:______

PATIENT NAME:____DOB: ____________________

LONG-TERM SIDE EFFECTS:

The long-term effect of opioid/narcotic therapy is not fully known. Most of the long-term effects have been listed above. If you have additional questions regarding the potential long-term effects of opioid/narcotic therapy, please speak with your physician.

PRESCRIPTIONS AND USE OF OPIOID/NARCOTIC MEDICATIONS

Your medication will be prescribed by your physician for control of pain. Based on your individual needs, you will be provided with enough medication on a monthly basis, two-month basis, or three-month basis. New injuries or pain problems will require reevaluation. Prescriptions for opioids/narcotics will not be "called in" to the pharmacy.

You agree that you must be seen by your physician at a minimum of every three months during the course of your therapy.

You agree and understand that increasing your dose without the close supervision of your physician could lead to drug overdose, causing severe sedation, respiratory depression and/or death.

You agree and understand that opioid/narcotic medication is strictly prescribed for you, and your opioid/narcotic medication should NEVER be given to others.

You agree to fill opioid/narcotic prescriptions at one pharmacy.

You agree to secure your opioid/narcotic medications in safe, locked source to prevent loss or theft. You are responsible for any loss of theft.

You agree that lost, stolen or destroyed prescriptions or drugs will not be replaced, and may result in discontinuation of treatment.

You agree to obtain opioid/narcotic medication from one prescribing physician or that physician's substitute if your prescribing physician is not available and your prescribing physician has authorized his or her substitute to provide treatment.

You agree to submit to an initial examination and evaluation. to routine examination and evaluation on a monthly basis or regular basis (but no less than once every three months), and to examination and evaluation at the direction of your physician.

You agree to submit to blood and/or urine testing to monitor the levels of medication or other drugs and any organ side effects. You also agree that other doctors and law enforcement may be notified of the results.

You agree NOT to call the physician for refills or replacement medications during evening hours or on weekends/holidays. Medication refill and/or replacement requests will be addressed during regular business hours only.

You understand and agree that if you lose your medication or run out early due to overuse, you may experience and go through withdrawal from opioids/narcotics. You further understand and agree that you are solely responsible for your own medications.

You agree to bring all prescription medications in their bottles or containers to the office during regularly scheduled visits.

You agree to provide a list from your pharmacy detailing all medications received from that pharmacy and to provide updated lists as requested by your physician.

For patients taking methadone: Methadone has significant interactions with many other medications. Some of these medications may reduce your body's ability to metabolize methadone, thus INCREASING the methadone in your body, which could be dangerous. Therefore, you MUST notify this office of ALL medications prescribed for ANY condition while taking methadone.

PATIENT'S INITIALS:______

PATIENT NAME: ____ DATE: ____________________

OPIOID/NARCOTIC THERAPY MAY BE <u>DISCONTINUED</u> IF YOU:

- develop progressive tolerance which cannot be managed by changing medications;
- experience unacceptable side effects which cannot be controlled;
- experience diminishing function or poor pain control;
- develop signs of addiction;
- abuse any other controlled substance (this may be determined by random blood/urine testing);
- obtain and or use street drugs (this may be determined by random blood/urine testing);
- increase your medication without the consent of your physician;
- either refuse to stop or resume smoking;
- obtain opiates/narcotics from other physicians or sources;
- fill prescriptions at other pharmacies without explanation;
- sell, give away, or lose medications;
- fail to submit to routine examination and evaluation on a monthly basis or regular basis (but no less than once every three months), or as directed by your physician;
- fail to bring your prescription medications to your regularly scheduled visits;
- fail to submit to blood/urine testing as directed;
- call for refills during evenings, weekends or holidays; or
- violate any of the terms of this agreement.

By signing below, Patient acknowledges and agrees that: (i) I have read and fully understand the Physician/Patient Informed Consent and Agreement for Long-Term Opioid/Narcotic Therapy for the Treatment of Chronic Pain; (ii) I have been given the opportunity to ask questions about the proposed treatment (including no treatment), potential risks, complications, side effects, and benefits; (iii) I knowingly accept and agree to assume the risks of the proposed treatment as presented; and (iv) I agree to abide by the terms of this agreement

Patient Signature: ______________________________________ Date: ____________________

Print Name: ______________________________________

Witness Signature: ______________________________________ Date: ____________________

Print Name: ______________________________________

Physician Signature: ______________________________________ Date: ____________________

Print Name: ______________________________________