Name:____________________ DOB:____________________

Advanced Spine and Pain

PATIENT RESPONSIBILITY FOR CHRONIC OPIOID (NARCOTIC) THERAPY

This document represents patient expectations regarding the use of opioid (narcotic) pain medications for treating my pain. Opioid medications are only one part of an overall treatment plan; therefore, I will regularly attend and participate in all prescribed therapies. By signing this, I understand and agree to the following risks and conditions, which may be associated with long-term use of opioid medications.

RISKS:

1. Constipation (which may be severe enough to require medical treatment)
2. Urinary retention (difficulty with urination)
3. Change in appetite and/or in weight
4. Drowsiness or confusion which may affect thinking abilities or emotions
5. Itching
6. Nausea
7. Problems with coordination or balance that may make it unsafe to operate motor vehicles or heavy equipment
8. Depressed respiration (breathing too slowly, overdose can lead to respiratory arrest, coma or death)
9. Physical dependence (which means that quickly stopping opioids may lead to withdrawal symptoms)
10. Psychological dependence (which means that quickly stopping opioids may lead to drug cravings)
11. Sexual difficulties
12. If I become pregnant, my baby might be born physically dependent on opioids. This can be treated successfully. There may be other, unknown risks to unborn children (female patients only)
13. Other, rare side effects may occur

Initial _______

Conditions

1. I am not currently using any illegal pain medication. I have fully informed my physicians of any current, previous use, sale or diversion of legal or illegal drugs. (i.e. cocaine, cannabis, heroine, etc.)
   *****We also ask that you please inform your physician if you are on probation*****

   Are you on Probation: ____Yes ____No

   If yes, reason:

   ____

   ____

   Name of Probation Officer: ______________________ Ph#:_____________

2. I am not currently abusing alcohol, and have fully informed my physicians about any previous alcohol abuse.

3. I will obtain all prescriptions for opioids only from ASAP physicians. I am not permitted to obtain similar medication from any other doctor or clinic without the expressed authorization of ASAP physicians. If an emergency occurs and opioid medications are prescribed from another doctor, I will notify ASAP physicians as soon as possible.

4. Prescriptions will not be mailed, unless otherwise specified.

5. I will take opioids only as prescribed by ASAP physicians and under no circumstances will I allow other individuals to use these medications, nor will I obtain these medications from other individuals.

6. The use of these medications will be ***strictly*** monitored.

7. Extra medication will not be given if the prescription runs out early due to excessive use. Lost, stolen, or misplaced prescriptions or medications will not be replaced.

8. No unplanned or emergency refills will be allowed. ***No prescriptions will be filled or renewed over weekends, after 4 pm on weekdays, or on holidays***.

9. Patients needing refills must call the office at least 5 days before current supply of opioid pain medications run out.

10. Prescriptions and refills ***Will Not*** be telephoned into pharmacies, and must either be picked up by patients, or mailed to pharmacy via standard delivery mail

11. Only on pharmacy will be used to fill prescriptions. ASAP physicians have my permission to communicate with the pharmacist about my use of medications. If I change pharmacies, I will notify ASAP in advance

Pharmacy Name:_________________________ Ph#:_____________________

Initial _______

12. I will be required to have unannounced blood or urine tests, or pill counts in order to assess the effect of the opioid as well as my abstinence from illegal drug use. By signing this patient responsibility form, I give permission for and agree to cooperate with any such test if I am asked to do so; failure to comply may result in discharge from the practice.

13. Before receiving any opioids, a psychological evaluation with follow up therapy may be required by the physicians at ASAP. Other medical evaluations and/or treatments nay also be required.

14. Due to known and unknown risks to unborn children, which include physical dependence, I will notify my physician if I am pregnant or if I become pregnant in the future.

15. I understand that opioid medications will be slowly reduced and safely stopped if I violate any aspect of this patient responsibility form (at the discretion of the provider), or if the ASAP physicians feel that opioids are not effective in controlling my pain. It may be necessary for me to enter a chemical dependence program in order to completely stop the medication.

16. I must visit the ASAP physicians at ***least every four to eight weeks*** for monitoring my medications. I understand that if I don't show for my regular scheduled appointment, I may not receive my refill medications. After three No Show appointments, I may be subject to discharge due to noncompliance.

17. I give ASAP physicians permission to communicate with any of my other physicians regarding my use of controlled substances.

18. I take all responsibility for the cost of medication, urine/blood tests, which insurance may not cover.

19. I understand that any violation of the above terms may lead to my immediate discharge from the office.

20. Other conditions: ____

I have read and understand this agreement, and I agree to all of the above. I will be given a copy of this form and I give permission for a copy to be sent to my other treating physicians, caregivers, pharmacists, and insurance providers.

Patient: ________________________________ Date: ________________________

Physician: ______________________________ Date: ________________________

Witness: _______________________________ Date: ________________________

INTERPRETER'S STATEMENT: I have translated the information and advice presented orally to the individuals giving consent by the person obtaining this consent. To the best of my knowledge and behalf, he/she understood this explanation.

Interpreter: _____________________________ Date: ________________________