Innovative Pain Solutions Centers

Patient-Physician Agreement for Opioid Use

I have agreed to use opioids (morphine-like medications), also called narcotics, as part of my treatment for chronic pain. I understand that these medications can be very useful but have a potential for misuse and therefore closely controlled by the local, state and federal government. I understand my physician is prescribing this medication to **help manage my pain and increase my function.** Signing this document does not entitle a patient to opioid prescription. The physician/provider will make that decision after evaluating the patient and also at his/her sole discretion. By signing this agreement, I agree to follow the rules and regulations listed below.

1. I am responsible for my opioid pain medications. I agree to take the medications only as directed. I understand that increasing my dose without the supervision of my physician could lead to drug overdose. Drug overdose can cause severe sedation (sleepiness), slowed breathing and possible death.
   I understand that decreasing or stopping my opioid medication without the supervision of my physician could lead to withdrawal. Withdrawal symptoms may include yawning, "gooseflesh", abdominal cramps and diarrhea. These symptoms can occur 24-48 hours after the last dose of medication and can last up to 3 weeks.
2. I **will not** request or accept opioid pain medication from any other physician or individual while I am receiving this medication from **Dr. Oppong, Dr. Forsythe, et al.**, unless it is an emergency and then I am responsible for notifying **Dr. Oppong, Dr. Forsythe, et al**. within 24 hours or the next business day.
3. I understand there are side effects related to opioid medication. Common side effects include nausea and vomiting (similar to motion sickness), drowsiness and constipation. If I experience constipation I may need to take stool softeners. Less common side effects are mental slowing, flushing, sweating, itching, urinary difficulty and jerkiness. These side effects would occur at the beginning of my treatment and often go away within a few days without treatment. It is my responsibility to notify my physician of any side effects that continue or are severe (such as drowsiness, severe constipation or confusion).
4. I am responsible for notifying my pain physician immediately if I become pregnant or plan to become pregnant.
5. I understand the opioid medication is strictly for my own use. The opioid medication should never be given to others. If children are in the house, a childproof top is necessary and the medication should be kept in a safe place out of reach of children.
6. I understand I must contact my pain physician before taking benzodiazepines (such as Valium, Xanax or Ativan), sedatives (such as Soma, Fiorinal or sleep medications) and antihistamines (such as Benadryl). The use of these medications or alcohol with opioid medication may produce drowsiness, slowed breathing, blood pressure drop and even death.
7. I agree to submit to oral, urine or blood screens at any time as determined by my physician to detect both the use of prescribed and non-prescribed medications.
8. I will not use street drugs (such as marijuana, cocaine, heroin, ecstasy) while on opioid medication. If I do, the opioid medication will be discontinued.
9. During the time my dose is being adjusted I will be expected to return to **Innovative Pain Solutions Centers** for my scheduled visits. Once I have been placed on a stable dose, I will return to my referring physician or my primary care physician as instructed.
10. I am responsible for my opioid prescriptions. I understand:

- Prescriptions should be filled at the same pharmacy.
- Prescriptions should be obtained during regular clinic appointments.
- Prescriptions cannot be obtained at night, on holidays or weekends.
- If a conflict arises such as extensive travel plans or moving, I am responsible for notifying from **Drs. Oppong, Dr. Forsythe, et al.** well in advance (at least 14 days) to discuss a plan for my prescriptions.

- **Prescriptions will not be given if I "run out early" or "lose a prescription", spill or misplace my opioid medication. I am responsible for taking my medication in the dose prescribed and for keeping track of the amount remaining.**
- If my medication is stolen, I will notify the police and obtain a stolen item report. At the discretion of my physician, replacement prescriptions may or may not be given. I am responsible to keep my medication in a safe place.

11. While physical dependence is to be expected after long-term use of opioids, signs of addiction and psychological dependence shall be interpreted as a need for weaning or slowly discontinuing the opioid medication.

- **Physical Dependence** is common to many medications such as blood pressure medications, anti-seizure medications and opioids. Taking these type medications results in biochemical changes in your body (your body becomes used to these medications). Should you abruptly stop taking the opioid medication you may go through withdrawal.
- **Addiction** is a psychological and behavioral syndrome that is recognized when a patient abuses the opioid medication to obtain mental numbness or "get high" or drug craving behavior such as "doctor shopping" or being rude and manipulative to the physicians and staff in attempts to obtain opioid medication.

12. If it appears to the physician that there is no improvement in my daily function or quality of life from the opioid medication, my opioids may be tapered down and discontinued.
13. A Primary Care Physician (PCP) is important for my continuing healthcare needs. I am responsible to have a Primary Care Physician and should I change my PCP, I will notify **Drs. Oppong, Dr. Forsythe, et al. or Innovative Pain Solutions Centers.**

I further understand if I do not follow the above agreement, I will no longer receive any opioid medication from another healthcare provider or any other means. It is my responsibility to contact **Drs. Oppong, Dr. Forsythe, et al.** to clarify or discuss any issues before a problem or crisis situation arises. I understand I may be required to make a follow up appointment to see the physician.

I, _____ have read the above information (or it has been read to me). I have received a copy of the contract and my questions regarding the treatment of chronic pain with opioids have been answered. I hereby give my consent to participate in opioid medication therapy.

X_____ Date_____

Patient Signature

Pharmacy _____