OPIOID TREATMENT AGREEMENT FOR THE PAINLESS CENTER

Patient Name: ____________________________

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. Opioid is deemed the last resort and is only prescribed while adhering to other non-opioid treatment modalities.

I, _______________________________, understand that compliance with the following guidelines is important in continuing pain treatment with the Painless Center LLC.

1. 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 the doctor.
   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 provider from 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, 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 sign of belligerence and signs of addiction toward the office staff or provider at the Painless LLC

Patient Signature: ____________________________ Date: ____________________________

If I have an addiction problem, I will not use illegal or 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 may include the following:

12-step program and securing a sponsor Individual counseling
Inpatient or outpatient treatment including suboxone or infusion treatments.

2. 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 a consent to request record transfer to this doctor. No more than 3 days of medications may be prescribed by the emergency room or other physician without this doctor’s approval.
3. I understand that I will consent to random drug screening. 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.

4. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.

5. I understand that this doctor may stop prescribing opioids or change the treatment plan if:
   1. I do not show any improvement in pain from opioids or my physical activity has not improved.
   2. My behavior is inconsistent with the responsibilities outlined in #1 above.
   3. I give, sell or misuse the opioid medications.
   4. I develop rapid tolerance or loss of improvement from the treatment.
   5. I obtain opioids from other than from the provider of the Painless Center LLC.
   6. I refuse to cooperate when asked to get a drug screen.
   7. If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.
   8. If I am unable to keep follow-up appointments.

**RISKS:**

**OPIOID TREATMENT AGREEMENT THE PAINLESS CENTER (continued)**

**YOUR SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF OPIOIDS:**

You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness and tolerance. Also, you should know about the possible danger associated with the use of opioids while operating heavy equipment or driving.

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.

**SIDE EFFECTS OF OPIOIDS:**

- Confusion or other change in thinking abilities
- Nausea
- Constipation
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
- Sleepiness or drowsiness
- Aggravation of 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.

Use of a medication box that you can purchase at your pharmacy that is already divided in to the days of the week and times of the day so it is easier to remember when to take your medications.

Take along only the amount of medicine you need when leaving home so there is less risk of loosing all your medications at the same time.

I have read this document, understand 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