



Oral Opioid (Narcotic) Consent Form and Management Agreement

This agreement between the undersigned (patient) and Edward J. Kowlowitz, M.D. and/or John J. Fitzgerald, M.D. and/or Karen Schloemer, M.D. and/or Jocelyn L. Bush, M.D. and/or Sheila Y. Abebe, APRN, BC, FNP is to establish clear conditions for the prescription and use of controlled substances and pain medication prescribed by the doctor for the patient. Doctor and patient agree that this agreement is an essential factor in maintaining the trust and confidence necessary in a doctor-patient relationship. The patient agrees to and accepts the following conditions for the management of pain medication prescribed by the doctor for the patient:

1. Opioid medication may be prescribed for me ONLY by Dr. Kowlowitz and/or Dr. Fitzgerald and/or Dr. Schloemer and/or Dr. Bush and/or Sheila Y. Abebe, APRN, BC, FNP.
2. I will not solicit nor accept a prescription for opioid medication from any other physician without the prior written consent of one of the above staff.
3. I will take the prescribed medication only at the dose, frequency, and drug as prescribed.
4. I will not, under any circumstance, increase my dose or frequency without my doctor's permission.
5. I will and do consent to random drug screening at the doctor's request.
6. I will not use any illegal substances, including marijuana, cocaine, amphetamine, etc.
7. I will not use this medication with any alcohol-containing beverages.
8. I will not share, sell, or trade my medication for money, goods, or services.
9. I will not undergo any pain management procedures or injections without the preceding consent of Dr. Kowlowitz and/or Dr. Fitzgerald and/or Dr. Schloemer and/or Dr. Bush. Patients are free to transfer their interventional care at any time; we would expect those physicians to assume continued prescribing of all controlled substances.
10. I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my medication for a period of time, and may precipitate a re-evaluation of my competence to continue on these medications.
11. I understand that an important part of my pain management program may include non-drug treatment. If I fail to follow-through with my doctor's treatment program, I understand and agree that opioids may be withdrawn.
12. I understand that reduction in the intensity of my pain as well as improvement in my quality of life and function-ability are the desired goals of treatment. Should it become evident to my doctor that these objectives are not being met with the use of opioids, I agree to weaning and discontinuation of narcotic medication.

I understand that the long-term advantages and disadvantages of chronic opioid have yet to scientifically determined and that treatment may change throughout my time as a patient. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances and my doctor will advise me as knowledge and training advance and will make appropriate treatment changes.

I understand that all medications have potential side effects. I have been fully informed by the doctor of the potential side effects including, but not limited to: Physical dependence, pseudo-addiction, chemical dependence, addiction, constipation which may be severe enough to require medical treatment, difficulty with urination, drowsiness, cognitive impairment, nausea, itching, depressed respiration, reduced sexual function and adverse effects or injury to organs. A distinct clinical syndrome, "Hyperalgesia Syndrome", has been described in the literature and can result in increased pain from continual and escalated doses of opioid medication. If I take more medication than prescribed, a dangerous situation could result such as coma, organ damage, or even my death.

I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment in my ability to safely perform any activity, I agree not to attempt to perform such activity until my abilities have been properly evaluated and/or my medications have been held for four days.

I agree to waive any applicable privileges or right of privacy or confidentiality with respect to prescription medication and I authorize one of the above staff and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency including the Indiana Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I understand that my physician or nurse practitioner may utilize the INSPECT website to further assess my compliance.

I agree to the following regarding prescription refills: Prescription refills of my medication will be made only during regular office hours, in person, once every month during a scheduled office visit, or more frequently as recommended by my doctor and/or nurse practitioner. Refills will not be made on an emergency basis, nights, weekends, or holidays. I am free to visit an ER or other physician and have them contact my doctor in any emergency situation.

I agree to be evaluated by a psychologist and/or addiction specialist at any time during my treatment at my doctor's request. If, in their opinion, I am not a candidate for further narcotic treatment, I agree to weaning and treatment discontinuation.

(Females only): Narcotics are felt to have minimal risk for development of birth defects. However, if I continue to take these medications throughout pregnancy, my child will be born drug-dependent and need specialized care. I therefore agree that if I plan to become pregnant, or believe I have become pregnant while on these medications, I will immediately notify my obstetrician and Dr. Kowlowitz and/or Dr. Fitzgerald and/or Dr. Schloemer and/or Dr. Bush and/or Sheila Y. Abebe, APRN, BC, FNP.

Doctor and patient agree that this agreement is essential to the doctor's ability to treat the patient's pain effectively and that failure of the patient to abide by the terms of this agreement may result in the withdrawal of all prescribed medication by the doctor and the termination of the doctor-patient relationship.

Examples of opioid medication include: Lortab, Fentanyl, Opana, Vicodin, Norco, OxyContin, MS Contin, Percocet, Kadian, Avinza, Tylox, Methadone, Demerol, Dilaudid, Darvocet, Codeine, Subutex, and Suboxone. It is my responsibility to know these and other medications which are opioid compounds which I may be taking.

Acknowledgement

I have read or have had the above form read to me and understand all of it. I have had a chance to have all my questions answered to my satisfaction. By signing this form voluntarily, I give my consent for treatment of my painful condition with opioid medications.

Patient Signature: _____

Doctor Signature: _____

Date: _____

Witness (receipt of copy of agreement): _____