

CONSENT FOR CHRONIC OPIOID THERAPY

This agreement between (Patient) and/or Dr. Kowlowitz and/or Dr. Schloemer and their staff is for the prescription of medication for a serious painful condition that has failed to respond to other modalities. I understand that the long-term advantages and disadvantages of chronic opioid therapy have yet to be scientifically determined and therefore treatment may change throughout my time as a patient. I understand and accept that there may be unknown risks associated with the use of these medications and my doctor will advise me as knowledge advances and I agree to treatment changes on my doctor's recommendations.

I have been fully informed, and I am aware that the use of these medications have associated risks including but not limited to: Sleepiness, drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reactions, slowing of the breathing rate, reflexes or reaction time, physical dependences, tolerance to analgesia, addiction and the possibility that this medication will not provide adequate or complete pain relief. If I take more medication than prescribed, a dangerous situation could result in coma, organ damage, or death. I am aware that chronic opioid therapy has been associated with low testosterone levels and may affect mood, stamina, sexual desire and performance.

I realize that it is my responsibility to keep others and myself from harm, including the driving of a motor vehicle, use of heavy equipment, working in unprotected heights, or being responsible for individuals who are unable to care for themselves. If there is any question of impairment I agree not to perform such activities until a physician has properly evaluated me. I am aware that medications called opioid antagonists or partial antagonists such as Nubain, Talwin, Stadol, and Buprenex will reverse the actions of my medications and could precipitate a withdrawal syndrome. I agree to be both complete and honest with regard to my past, present, and family drug history with all my doctors.

The patient agrees to and accepts the following conditions related to the prescribing of their pain medications:

1. Only Dr. Kowlowitz and/or Dr. Schloemer and their staff will prescribe opioid pain medication.
2. I will not solicit nor accept opioid medication from any other physician without the prior consent of Dr. Kowlowitz and/or Dr. Schloemer.
3. In addition, I will not undergo any pain management procedures or injections without the preceding consent of Dr. Kowlowitz and/or Dr. Schloemer. Patients are free to transfer their interventional care at any time; we would expect those physicians to assume continued prescribing of all controlled substances.
4. I will take medication only in the dosing and frequency prescribed by my doctor.
5. I will not, under any circumstance, increase my dose or frequency without prior permission from my doctor.
6. I will and do consent to random urine drug screening at my doctor's request. (I understand that refusal to provide a sample is grounds for immediate discharge from the practice and aberrant drug behavior will be the discharge diagnosis.)
7. I will not use any illegal substances including Marijuana, Cocaine, Speed, Hallucinogen, etc.
8. I will not use this medication in conjunction with excessive alcohol, nor will I share, sell, or trade my medication for money, goods, or services.
9. I will safeguard my medication from loss or theft, and agree that my failure or negligence to do so may cause me to be without medication for a period and precipitate a reevaluation of my competence to continue on this medication. I understand that a police report following disappearance of my medication has no value in excusing my lack of safeguarding and is not a factor in replacement of these medications.
10. I understand that an important part of my pain management program may include non-drug treatment and that continued prescription of these medications is contingent upon a clear improvement in my pain control, daily function, and/or quality of life. Should it become evident to my doctor that these objectives are not being met, I agree to weaning and discontinuation of narcotic medication.

CONSENT FOR CHRONIC OPIOID THERAPY
PAGE 2

11. Prescription refills will be made only during regular office hours, in person, once every month during a scheduled office visit or more frequently as recommended by the doctor. Refills will not be made on an emergency basis, nights, weekends, or holidays.

Examples of Opioids include: Hydrocodone, Lortab, Vicodin, Norco, OxyContin, Percocet, Tylox, Codeine, Ultram, Morphine, MS Contin, Kadian, Avinza, Demerol, Dilaudid, Darvocet, Levorphanol, Methadone, Duragesic.

(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 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. Schloemer.

I agree to waive any rights of privacy or confidentiality with respect to prescription medication and I authorize Dr. Kowlowitz and/or Dr. Schloemer 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 pain medication. I understand that Dr. Kowlowitz and/or Dr. Schloemer will report all diversionary behavior and expect this to result in arrest and criminal prosecution.

I agree to be evaluated by a psychologist or an 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.

Doctor and Patient agree that this agreement is essential to the Doctor's ability to effectively treat the patient's medical condition 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 termination of the doctor/patient relationship.

I have read or 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 _____ Date _____

Witness to above _____ Date _____