Oral Opioid (Narcotic) Consent Form and Management Agreement

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This agreement between the undersigned (patient) and Edward J. Kowlowitz, M.D. and/or John J. Fitzgerald, M.D. and/or Jocelyn L. Bush, M.D. and/or Scott S. Kim, M.D. and/or Saima Kamal, M.D. and/or David Miller, M.D. and/or David Gordon, M.D. and/or Sandra Dolny, PA-C and/or Ted Westlund, PA-C and/or Dena Seifert, NP and/or Caroline Asava, NP and/or Susan Sipes, NP and/or Jennifer Emmet, NP and/or any other provider at the Center for Pain Management is to establish clear conditions for the prescription and use of controlled substances and pain medications 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 medications prescribed by the doctor for the patient:

1. Opioid medications may be prescribed for me ONLY by Edward J. Kowlowitz, M.D. and/or John J. Fitzgerald, M.D. and/or Jocelyn L. Bush, M.D. and/or Scott S. Kim, M.D. and/or Saima Kamal, M.D. and/or David Miller, M.D. and/or David Gordon, M.D. and/or Sandra Dolny, PA-C and/or Ted Westlund, PA-C and/or Dena Seifert, NP and/or Caroline Asava, NP and/or Susan Sipes, NP and/or Jennifer Emmet, NP.
2. I will not solicit nor accept prescriptions for opioid medications from any other physician without the prior consent of one of the above staff.
3. I will only take the prescribed medications and only at the dose and frequency 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 testing and random pill counts 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 take any prescription or nonprescription sleep aid without first discussing it with my doctor and obtaining my doctor's permission, including Klonopin, Xanax, Valium, or Ativan.
9. I will not share, sell, or trade my medication for money, goods, or services.
10. I will not undergo any pain management procedures or injections without the preceding consent of any of the above treating providers. Patients are free to transfer their interventional care at any time; we would expect those physicians to assume continued prescribing of all controlled substances.
11. 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 this may precipitate a re-evaluation of my competence to continue on these medications.
12. I understand that an important part of my pain management program may include procedural and other non-drug treatment. It is the intention of the treating physician and I that the chronic opioid therapy I am currently on will be titrated to the lowest effectual dose with an eventual expectation of weaning and discontinuation of opioids when they become ineffectual, the risks outweigh the benefits, or they become unnecessary. If I fail to follow-through with my doctor's treatment program, I understand and agree that opioids may be withdrawn. Adjuvant medications, such as NSAID's, anti-inflammatories, muscle relaxants, anticonvulsants, and antidepressant medications may continue to be given.
13. 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 further understand that as the regulatory and consensus opinions regarding what is considered to be a "safe dose" of opioid prescribed is reduced, my dose may be further titrated accordingly; even if it negatively affects my perceived level of pain control. I understand that certain antibiotics/antifungals can affect the metabolism of my medications. I will discuss these issues with my pharmacist. My physician may need to reduce my dosage accordingly.

I understand that the long-term advantages and disadvantages of chronic opioid have yet to be scientifically determined and that opioid 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, in addition to the obvious of tolerance, dependence, drug overdose, and death. These risks increase with the increased dosage and with the combination of opioids with certain other medications and opioids with alcohol, especially over 40 mEq of morphine per day. My doctor will advise me as knowledge and training advance and will make appropriate treatment changes.

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I understand that all medications have potential side effects. I understand that the risks of opioid medications increase with increased dosage. 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, adverse effects or injury to organs, and death. 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 provider 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 provider. 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 Edward J. Kowlowitz, M.D. and/or John J. Fitzgerald, M.D. and/or Jocelyn L. Bush, M.D. and/or Scott S. Kim, M.D. and/or Saima Kamal, M.D. and/or David Miller, M.D. and/or David Gordon, M.D. and/or Sandra Dolny, PA-C and/or Ted Westlund, PA-C and/or Dena Seifert, NP and/or Caroline Asava, NP and/or Susan Sipes, NP and/or Jennifer Emmet, NP and/or any other provider at the Center for Pain Management.

*I understand that if I continue to take opioid medications during my pregnancy, my baby will be at risk for opioid dependency and neonatal abstinence syndrome.

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, but are not limited to: Lortab, Fentanyl, Opana, Vicodin, Norco, OxyContin, MS Contin, Percocet, Kadian, Avinza, Tylox, Methadone, Demerol, Dilaudid, Belbuca, Buprenorphine, Xtampza, 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): _____