

Pain Treatment Agreement

This Agreement between _____ (“Patient”) and Pain Consultants (“Doctor”) is for the purpose of establishing agreement between Doctor and Patient on clear conditions for the prescription and use of pain controlling 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 medication prescribed by the Doctor for the Patient:

- I understand that a reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program. _____ (initials)
- I realize that all of the medications have potential side effects, and I will have the recommended laboratory studies required to keep the regimen as safe as possible. _____ (initials)
- 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 of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until I have not used my medication for at least four days. _____ (initials)
- I agree that refills of my prescriptions of pain medicine will be made only at the time of an office visit or during regular office hours. I agree to give at least 5 business days’ notice for refill requests. No refills will be available during evenings or on weekends. _____ (initials)
- I will not use any illegal controlled substances, including marijuana, cocaine, etc. _____ (initials)
- I understand that if I use medical marijuana, I will not be prescribed any opioids. _____ (initials)
- I will not share, sell, or trade my medication for money, goods, or services. _____ (initials)
- I will get all pain medication from ONLY ONE health care provider. If my primary care physician is willing to prescribe my medications, the Doctor will have to approve the arrangements to make sure there isn’t any duplication. **I WILL DISCONTINUE AND DISPOSE OF ALL PREVIOUSLY USED PAIN MEDICATIONS UNLESS TOLD TO CONTINUE THEM.** _____ (initials)
- I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is a violation of this agreement, and I will no longer be prescribed opioid medication. _____ (initials)
- I agree to use (name of 1 Pharmacy) _____ located in _____, Telephone number _____, for all of my pain medication. If I change pharmacy for any reason, I agree to notify the Doctor at the time I receive a prescription, and advise my new pharmacy of my prior pharmacy’s address and phone number. _____ (initials)
- I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my pain medication, and I authorize the Doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize the Doctor to provide a copy of this Agreement to my pharmacy. _____ (initials)
- I agree that I will submit to a blood or urine test if requested by my Doctor to determine my compliance with this agreement and my regimen of pain control medication. _____ (initials)
- I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate may result in significant harm and is a violation of this agreement. _____ (initials)
- I will bring all unused pain medication to be counted by the nurse whenever requested and at every visit. _____ (initials)
- I agree that one missed appointment or cancellation would be a breach of the agreement and may lead to dismissal. _____ (initials)
- I agree to comply fully with all aspects of my treatment program including, but not limited to, behavioral medicine (psychology/psychiatry) and physical therapy, if recommended. Failure to do so may lead to discontinuation of my medication and referral to an outside physician. _____ (initials)
- Successful pain management entails employing multiple interventions, including but not limited to active participation in regular physical exercise. A pattern of passive reliance on medications, resistance to more active physical treatment, and repeated failure to demonstrate the compliance with the plan of care may lead to discontinuation of medications and/or referral to an outside physician. _____ (initials)
- I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. _____ (initials)

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, possibly causing Patient to experience withdrawal symptoms, and the termination of the Doctor-Patient relationship.** This agreement is entered into on this _____ day of _____, 20__.

CONSENT FOR CHRONIC OPIOID/CONTROLLED SUBSTANCE THERAPY

This document is called an "Informed Consent" form. The purpose of this document is to explain important information to you about the controlled substances (medications) your doctor recommends that you use to control your pain. You are responsible for reading this document, asking your doctor questions about the medications, and signing this form if you decide to use the recommended medications to control your pain. You will be given a chance to talk to your doctor about this information.

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.

Based on my statements to the doctor, and his review of my pain history and relevant medical records and tests, the doctor believes I have a medical condition called _____ and this causes me [acute, chronic, intractable] pain.

- I am aware about the possible risks and benefits of other types of treatments that do not involve the use of controlled substances. The other treatments options were discussed with my provider.
- I agree that I will submit to a blood or urine test if requested by my Doctor to determine my compliance with this agreement and my regimen of pain control medication.
- I will tell my doctor about all other medicines and treatments that I am receiving.
- I realize that all of the medications have potential side effects, and I will have the recommended laboratory studies required to keep the regimen as safe as possible. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. As with most medication, controlled or not, there are risks associated with use. In general, using controlled substances or "narcotics" may put you at risk for the items listed below:
 1. BRAIN - Sleepiness, difficulty thinking, confusion. **It is important for you to consider how your use of the prescribed medication might affect your ability to operate a motor vehicle or other heavy machinery. IT IS YOUR RESPONSIBILITY TO FOLLOW THE LAWS IN THIS STATE REGARDING THE OPERATION OF A MOTOR VEHICLE WHILE USING CONTROLLED SUBSTANCES. Likewise, for those licensed to carry weapons, you must consider whether you have an obligation to report your use of controlled substances to your employer. If you have a concern about these issues consult your attorney or call the Department of Transportation, Driver's License Bureau, or Weapons Licensing Bureau.**
 2. LUNG – Difficulty breathing, shortness of breath, wheezing, slows the breathing rate.
 3. STOMACH – Nausea, vomiting and constipation
 4. SKIN – Itching, rash
 5. URINARY – Difficulty urinating
 6. ALLERGY – Potential for allergic reaction
 7. DRUG INTERACTIONS – Possibility of interaction with other medications – Can make the effect of both drugs stronger when taken together. I am aware that certain other medicines such as nalbuphine (Nubain), pentazocine (Talwin), buprenorphine (Buprenex), and butorphanol (Stadol) may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of the medicines listed above. **If I want to know more about these risks, I will ask my doctor after I finish reading this form.**

Ohio County Pain Care

A Division of Ohio County Healthcare
1215 Old Main St.
Hartford, KY 42347



Patient Name:
Date of Birth:

- I am aware that **addiction** is defined as the use of a medication even if it causes harm, having cravings for a drug, feeling the need to use a drug. I am aware that the development of addiction has been reported in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.
- I understand that **physical dependence** is a normal, expected result of using medicines for a long time. I understand that **physical dependence** is not the same as **addiction**. I am aware that **physical dependence** means that if my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.
- I am aware that **tolerance** to analgesia means that I may require more medicine to get the same amount of pain relief. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.
 - **(MALES only)** I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire, and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.
 - **(FEMALES only)** If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medications; the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

Have you read and do you understand this document? (Initial one)

____ I was satisfied with the above description and did not want any more information.

____ I requested and received further explanation about the treatment, alternatives, or risks.

I agree to follow the terms of this agreement and I understand the risks, alternatives, and additional therapy associated with the use of controlled substances to treat my pain. I understand this document will be maintained as a permanent component of my chart.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Provider Signature _____ Date _____

You will get a copy of this form and we will keep a copy of it in your patient file.



PAIN TREATMENT AGREEMENT REVIEWED:

Patient Signature _____ Date / Time _____
Witness Signature _____ Date / Time _____

Patient Signature _____ Date / Time _____
Witness Signature _____ Date / Time _____

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