MIDJERSEY ORTHOPAEDICS
LIVE LIFE BETTER.

# Opioid Medication Treatment Agreement

Since other therapies have not been successful in controlling your pain, your physician, Dr. Salam agreed to initiate a trial of opioid medication. Some patients have an excellent response to Morphine and Morphine like drugs (opioids or narcotics). These patients experience a decrease in pain and an increase in their function. Unfortunately, not all patients have a favorable response to opioids and your physician cannot guarantee any favorable response or control of your pain. You may experience side effects, some of which might prevent further use of this type of pain medicine. The potential risks to using narcotics include:

1. Sedation
2. Nausea and/or vomiting
3. Constipation
4. Itching
5. Difficulty urinating
6. Swelling in your feet or legs
7. Decreased appetite
8. Breathing to slowly; overdose can lead to respiratory arrest and death
9. Confusion or other alteration in thinking
10. Problems with coordination and balance which may make it unsafe to operate dangerous equipment or motor vehicles
11. Sexual difficulties including impotence or diminished sex drive
12. Dry mouth; if persistent, this should be assessed by a dentist for proper tooth/gum care
13. Physical dependence: that is if you stop the medication abruptly you may experience a withdrawal syndrome characterized by one or more of the following: runny nose, anxiety, diarrhea, abdominal cramping, “goose flesh”
14. Psychological dependence: that is discontinuing the medication causes you to crave the medication; this is rare in patients who do not have a history of addiction (alcoholism or substance abuse) in their past
15. Tolerance: you may require higher doses of the medication to achieve the same results; this is usually not the case
16. Children born to mothers taking opioid(s) are likely to be born with physical dependence on the opioid(s)
17. Other less common risks and side-effects are possible

Please note that most side-effects, if they occur, are mild and temporary in nature. They are relatively easy to manage when addressed early. Difficulty breathing is a serious and very rare side-effect of these medications when taken as prescribed by your physician. If you have any difficulty breathing, discontinue the medications immediately and go to the nearest emergency room. Once again, this is a very rare side-effect of the medication.

**This <u>Opioid Medication Treatment Agreement</u> is designed so that you understand fully the guidelines which you must follow to take these medicines in a safe and proper manner. By signing this agreement, you agree to the following:**

1. I understand that the use of opioid analgesics can be safe and effective treatment for my chronic intractable pain if taken properly.

2. I understand that in using opioid analgesics there exists a risk of developing an addiction disorder, however, I also understand that this is extremely rare in patients who have no prior addiction history. I do not currently have problems with substance abuse or dependence.

3. I will not use any illicit substance while under the care of my physician.

4. I understand that I will not increase my dose of any medication prescribed for my pain unless I discuss this with my physician first.

5. I agree to fill any pain medicine prescriptions with only one pharmacy and will contact my physician when this is not possible.

6. I will not obtain opioid analgesics or any other pain medications from any other physician or health care provider unless I first discuss this with my physician. If I have to undergo a procedure such as dental work or surgery, I will discuss my pain management with my physician PRIOR to the procedure.

7. If I require treatment in an emergency room (ER) which necessitates opioids, I will inform the ER doctor of my present medications and ask him/her to call my physician.

8. I will not share or sell any of my pain medications. These medications are prescribed specifically for me. In particular, I will be sure to keep these medications out of reach of children at all times. I understand that if a child takes this medication, he/she can have serious and harmful side-effects including death from an overdose.

9. If my opioid pain medication or my prescription is stolen or lost, I will report it to my local police department and obtain a stolen/missing item report DC# (control number) which can be verified.

10. I agree to undergo immediate blood and/or urine screening when requested by my physician. This will be done to assess the effect of the opioid and assess my compliance with the regimen.

11. I will not suddenly stop taking this medication. I understand that if I do suddenly stop taking this medication I will experience some physical signs of withdrawal just as I might experience if I were to suddenly stop smoking cigarettes or suddenly stop drinking coffee. I understand these symptoms can be avoided by slowly going off the medication under the guidance of my physician. If at any point in time I wish to discontinue the use of these medications, I will call my doctor to obtain instructions on how to wean myself off the medication within one week in such a manner that I should not suffer withdrawal symptoms.

12. At the request of my doctor, I will seek psychiatric/psychological counseling to help me cope with my chronic severe intractable pain.

13. I will attend all scheduled outpatient appointments. Appointments will be scheduled monthly unless otherwise directed by my physician.

14. I understand that prescriptions for opioids cannot be called into a pharmacy and will not be mailed to my home. I must pick-up all prescriptions in person.

15. I will bring all my prescribed medications to my outpatient visits if requested by my doctor.

16. I will notify my doctor if I am pregnant or I become pregnant in the future.

17. I consent to allow my doctor to communicate with my referring physician, primary care physician, and/or my pharmacist regarding my use of opioids, my medical condition and treatment.

18. I consent and agree that any violation of the conditions established in this agreement may immediately result in my opioid pain medication(s) being tapered for the purpose of discontinuing them. I understand I will be discharged from needed care by my physician.

19. These conditions are only subject to change by my physician.

**I have read this document, understand it, and have had all my questions answered satisfactorily. I consent to use the opioids to manage my chronic intractable pain in the manner discussed above, and I understand that my treatment with opioids will be in accordance with the conditions stated above. I understand that no promises or guaranties of treatment results or control of my pain have been made to me by Hunterdon Orthopedics or my physician.**

_____ _____

Patient Name Account #

_____ _____

Patient Signature Date

_____ _____

Witness Name Date

_____

Pharmacy Name, Address, Phone #

**We certify that the above named patient or responsible individual has received an explanation of procedure(s) to be performed, including risks and benefits to be expected. We have disclosed alternative methods of management that might be appropriate for the patient.**

_____ _____

Physician Signature Date

_____ _____

Witness Signature Date