OPIOID TREATMENT AGREEMENT


Patient Name (Print): ____________________________________________

Prescriber Name (Print): __________________________________________

Medical Condition requiring Opioid: _________________________________

Planned Opioid Medication: ________________________________________

I (patient) understand the following (initial each):

_____ I understand this agreement applies to opioid medications. Some of the common examples include but are not limited to oxycodone (e.g., Percocet), hydrocodone (e.g., Vicodin, Lortab), Hydromorphone (Dilaudid), morphine, fentanyl (e.g., Actiq), codeine (e.g., Tylenol with codeine), methadone, tramadol (e.g., Ultram), and buprenorphine (Suboxone or Subutex).

_____ I understand that opioids are prescribed to see if they increase my function including my ability to work, perform household chores, or otherwise regain activities.

_____ I understand that opioids are only one part of my treatment program.

_____ I understand that opioids may slightly reduce pain levels. Most studies report this as approximately 1/10, or in other words, from a pain level of “6 out of 10” to “5 out of 10.” Opioids will NOT eliminate chronic pain and are unlikely to produce major improvements in pain.

_____ I understand that opioid medications have all of the following reported adverse effects (see Table 1a). Many, but not all of these risks increase with higher doses.

_____ I have had an opportunity to discuss these risks with my prescriber. I accept these risks.

Table 1a. Adverse Opioid Effects by Organ System

<table>
<thead>
<tr>
<th>System</th>
<th>Effect</th>
<th>Secondary Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td>Myocardial infarction</td>
<td>Heart attack</td>
</tr>
<tr>
<td></td>
<td>Orthostatic hypotension</td>
<td>Fainting on standing up</td>
</tr>
<tr>
<td></td>
<td>(dizziness on standing up)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Abnormal heart rhythm (QT</td>
<td>Sudden death</td>
</tr>
<tr>
<td></td>
<td>prolongation)</td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Gastroparesis (slow gut</td>
<td>Nausea, weight loss</td>
</tr>
<tr>
<td></td>
<td>movement)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduced colon motility; spasm</td>
<td>Constipation, bowel obstruction</td>
</tr>
<tr>
<td></td>
<td>Biliary spasm</td>
<td>Stomach pain</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>Exacerbation of prostate</td>
<td>Urinary retention</td>
</tr>
<tr>
<td></td>
<td>problems</td>
<td></td>
</tr>
<tr>
<td>Endocrine</td>
<td>Suppression of testosterone</td>
<td>Impotence or reduced sex drive and erectile dysfunction, osteoporosis, feminization,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>reduced muscle mass, reduced strength</td>
</tr>
<tr>
<td></td>
<td>Suppression of LH, FSH</td>
<td>Abnormal menstrual periods</td>
</tr>
<tr>
<td>Immune</td>
<td>Tumor spread</td>
<td>Hastening of death if cancer is present</td>
</tr>
<tr>
<td></td>
<td>Allergic reactions to</td>
<td>Rash, shortness of breath, itchy skin, edema</td>
</tr>
<tr>
<td></td>
<td>medication</td>
<td></td>
</tr>
<tr>
<td>Neurological/</td>
<td>Impairment of thinking or</td>
<td>Outbursts, inappropriate behavior, limit testing, violence, reduced impulse</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>executive function</td>
<td>control</td>
</tr>
<tr>
<td></td>
<td>Frontal lobe atrophy</td>
<td>Alterations in executive function, emotional</td>
</tr>
</tbody>
</table>

Copyright© 2017 Reed Group, Ltd.
Opioids will be initially prescribed to me on a trial basis. The primary goal of this treatment is to improve my ability to perform various functions, including return to work, household chores or other physical or mental activities. If significant demonstrable improvement in my functional capabilities does not result from this trial, my prescriber will likely end the trial.

Goal for improved function: ______________________________________________________

Opioids may also be prescribed to make my pain more tolerable, but these medications will not cause the pain to disappear entirely.

Drowsiness and slowed reflexes may be temporary or ongoing adverse effects of opioids, especially during dosage adjustments. If I am experiencing drowsiness while taking opioids, I agree not to drive a vehicle or perform other tasks that could involve danger to myself, family members, coworkers, or others.

Increased motor vehicle crashes have been reported in many studies among those taking opioids on a chronic basis. Especially for this reason, workers performing safety sensitive jobs (e.g., driving, operating heavy machinery, transporting goods or people, using overhead cranes, working at elevated heights, making complex judgments) are recommended to be precluded from performing safety sensitive jobs while taking opioids. If I am employed in a safety sensitive job, I will check with my employer to make sure this medication does not prevent me from working.
Due to evidence of crashes and accidents among those taking opioids, I also agree to discuss whether I can drive my personal car and/or operate machinery at home with my provider.

Using opioids to treat chronic pain will result in the development of a physical dependence on this medication, and sudden decreases or discontinuation of the medication will lead to symptoms of opioid withdrawal. These symptoms may include: nervousness, anxiety, difficulty sleeping, runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, vomiting, irritability, aches, and flu-like symptoms. I understand that opioid withdrawal is uncomfortable but not physically life threatening.

There is a risk that opioid addiction may occur. This most commonly occurs in, but is not limited to, patients with a personal or family history of other drug or alcohol abuse. If my prescriber of opioids believes I may be developing addiction, I should expect that I will be taken off opioids.

I agree to the following (initial each):

I agree to take the medication, ____________________________ (name) as prescribed. If problems arise, including adverse effects, I agree to promptly notify my prescriber.

I agree to obtain opioids from ONE designated licensed prescriber.

I agree to obtain opioids from ONE designated licensed pharmacist or pharmacy. By signing this agreement, I give consent to this provider to talk with the pharmacist.

I agree to take the following non-opioid medication(s) as prescribed:

I agree to attend and fully participate in all appointments, treatments, examinations and consultations of my pain treatment which may be requested by my prescriber at any time.

I agree to attend and fully participate in a regular exercise program if required. My specific exercise program is:

I agree to participate in fear avoidance belief training and/or cognitive behavior therapy if prescribed.

I will participate fully in any psychiatric or psychological assessments if necessary.

I agree to keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment. I agree to provide a reason for canceling any appointment.

I understand that lack of improvements in function or a later loss of those functional benefit(s) are reasons that my prescriber may discontinue the opioid.

I agree to NOT take more opioid medication than prescribed. I agree to NOT take doses of opioids more frequently than prescribed.

I agree that in the event of an emergency potentially requiring pain medication, I will notify the emergency department or other treatment facility of this agreement. I will ask that this prescriber be contacted and the problem should be discussed with the emergency department or other treating provider. I agree that no
more than 3 days of medications may be prescribed by the emergency department or other provider without this provider’s approval. If a situation arises in which I have no alternative but to obtain my necessary prescription from another prescriber (e.g., out of the country), I will then immediately advise my prescriber that I obtained a prescription from another prescriber.

____ I agree to keep the opioid medication in a safe and secure place. I will keep all medications away from children.

____ I understand that lost, damaged, or stolen medication will NOT be replaced.

____ I agree to immediately report stolen opioid medication(s) to the police. My provider will also produce a police report if requested to do so.

____ I agree not to share, sell, or in any way provide my medication to ANY other person.

____ I agree to not use ANY other mood-modifying drugs, including alcohol (and marijuana if legal in my state), unless agreed to by my prescriber. Use of nicotine and caffeine are exceptions to this restriction.

____ I agree to not use sedating over-the-counter medications, including diphenhydramine (e.g., Bendaryl).

____ I agree to discuss any medication with a warning label that states it causes drowsiness or sleepiness with my prescriber prior to taking it.

____ I agree to submit to unscheduled urine, blood, saliva, or hair drug testing at my prescriber’s request, to verify my compliance.

____ I agree that an abnormal urine, blood, saliva, or hair test will likely result in an end to the treatment with opioids. This includes a finding of a substance not expected (e.g., marijuana and/or illicit drugs).

____ I understand that, if applicable, my prescriber may check my state’s controlled substances database and/or Prescription Monitoring Database at any time to check my compliance.

____ I agree to be seen by an addiction specialist if requested.

____ I hereby agree that my provider has the authority to discuss my pain and opioid management with other health care professionals and my family members and/or significant others when it is deemed medically necessary in the provider’s judgment. I agree to involve family and/or significant others in periodic assessments of my progress.

I have read this document. I understand it and have had all my questions answered satisfactorily. I consent to the use of opioids to improve my functioning through hopefully controlling my pain. I understand that my treatment with opioids will be carried out as described above. I understand that ANY deviation(s) from the above agreement are grounds for my prescriber to stop prescribing opioids at any time.

Patient Signature ___________________________ Date ___________________________

Prescriber Signature ___________________________ Date ___________________________