midtown
PAIN AND SPINE CLINIC

A division of Eastern Carolina Anesthesia Associates, PLLC

Patient/Provider Opioid Treatment Agreement

This is an agreement between the undersigned patient and the providers at Midtown Pain and Spine Clinic concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of a chronic pain condition. The medication will probably not completely eliminate my pain but is expected to reduce it enough that I may become more functional and improve my quality of life.

1. I understand that opioid analgesics are strong medications for pain relief and have been informed of the risks and side effects involved with taking them.

2. I understand it is my responsibility to inform the doctor of any and all side effects I have from the medication. Common side effects may include drowsiness, nausea or constipation.

3. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.

4. I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable, but not a life-threatening condition.

5. (female) I will notify my obstetric doctor and this office immediately should I plan to become pregnant or believe that I am pregnant. I understand that my child would be physically dependent on the opioid medication and withdrawal can be life-threatening for a baby. I am aware that opioids are generally not associated with the risk of birth defects; however, there is always a risk while taking an opioid while pregnant or breast feeding.

6. (male) 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.

7. Tolerance may occur while taking opioid medication. This means that I may require more medication to get the same amount of pain relief. I will discuss this with my provider should this happen while taking the medication.

8. I agree to take the medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing provider. Running out early, needing early refills, escalating doses without permission, and losing prescriptions may be signs of misuse of the medication and the medication may be discontinued.

9. It is my responsibility to bring any medication prescribed by Midtown Pain and Spine Clinic in the original bottle to every visit, even if it is empty.

10. I will not dispose of my prescribed medication without permission from the office.

11. I agree that the opioids will be prescribed by only one doctor and I agree to fill my prescriptions at only one pharmacy. I agree not to take any pain medication or mind- altering medication prescribed by any other physician without first discussing it with the above-named doctor. I give permission for the doctor to verify that I am not seeing other doctors for opioid medication or going to other pharmacies.

12. No refills will be called in for opioid medications. I will anticipate the need for refills and make arrangements for a follow-up visit or call the office during business hours, Monday through Thursday 8-5 and Friday 8-2.

13. I agree to keep my medication in a safe and secure place, such as in a lock-box. Lost, stolen, or damaged medication will not be replaced.

14. I agree not to sell, lend, or in any way give my medication to any other person.

15. I agree not to drink alcohol or take other mood-altering drugs while I am taking opioid analgesic medication. I agree to submit

a urine specimen at any time that my doctor requests and give my permission for it to be tested for alcohol and drugs. Use of illicit substances may be grounds for discontinuing the medication.

16. I agree that I will attend all required follow-up visits with the doctor to monitor this medication and I understand that failure to do so will result in discontinuation of this treatment. I may be called into the office with my medication at any time for monitoring purposes.

17. I agree to participate in other chronic pain treatment modalities recommended by my provider.

18. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help.

19. I give my permission for the providers and/or medical staff at Midtown Pain and Spine Clinic to discuss my medical condition and opioid medication use with other treating physicians as well as legal authorities if deemed necessary.

I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the provider may discontinue this form of treatment.

Patient signature - date: _____

Provider signature - date: _____