Treatment Agreement & Informed Consent for Treatment with Controlled Substances

Note: this is a 4-page document. Initial the bottom of each page and sign the last page.

Patient name (print) ____

INTRODUCTION: I understand that therapy with controlled substances may be offered because my medical condition is serious and other treatments have not helped my condition in a manner acceptable to me; that my treatment with these medications is subject to review and revision; that I have been provided a simple and clear explanation of the key elements of my treatment plan; and that I am aware of and have been offered therapies for managing pain that do not involve controlled substances. I have been encouraged to ask questions and all of my questions have been answered to my satisfaction, understanding, and educational level. I understand controlled substances medications (i.e., opioid pain medications, tranquilizers, etc.) have a potential for harm and are therefore closely controlled by the local, state and federal governments. I understand that any medical treatment is initially a trial, with the goal of treatment being to improve my quality of life and my ability to function and/or work. My progress will be assessed periodically to determine the benefits of continued treatment. Continued use is dependent on whether my prescribing provider and I believe that the medication usage benefits me. I have the right to refuse treatment with these medications and ask for alternatives.

NOTE: I agree to not request or accept a controlled substance medication from any other prescriber or individual while I am a patient at Murphy Pain Center. However, if another licensed provider, after being made aware of my Murphy Pain Center Agreement, determines that it is in my best interest to administer or prescribe a controlled substance for me (such as after an acute injury, psychiatric illness, or surgery) I will notify Murphy Pain Center by phone by the next business day. This will not necessarily be viewed as a violation of the treatment agreement with Murphy Pain Center.

SIDE EFFECTS (INCLUDING OVERDOSE): I am aware that the use of these medicines has certain risks, including, but not limited to: sleepiness or drowsiness, severe constipation, sexual dysfunction, hormonal abnormalities, nausea, sweating, itching, rashes, vomiting, dizziness, allergic reactions, dangerous slowing of breathing rate, worsening of sleep apnea, blood pressure problems, irregular heart rate, slowing of reflexes or reaction time, impaired immunity, seizures, physical dependence, addiction, tolerance to pain medications, inadequate pain relief, worsening of pain, accidental overdose, and cardiac arrest. I understand that dangerous reactions can occur when my medications are used as prescribed and when used along with other prescribed drugs (even over-the-counter drugs), illicit drugs, or alcohol. I understand that use of opioids and other controlled substances can cause death by a number of means. An opioid overdose occurs when more opioids are consumed than the body can handle, slowing and then stopping breathing. Depending on which opioid and how much has been used, an opioid overdose can happen suddenly or slowly over a few hours. Without oxygen, a person loses consciousness, can get brain damage, and can die. If you identify an opioid overdose, call 911, give naloxone (if available), provide CPR and/or rescue-breathing.

RESPONSIBILITY TO AVOID CERTAIN ACTIVITIES: I understand that my reflexes and reaction time might be slowed by these medications. I pledge to not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or may not be thinking clearly. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights, or being responsible for another individual who is unable to care for himself or herself.

ADDED RISK OF HIGHER DOSES: I understand that the use of high-dose or chronic opioid therapy is controversial and is not recommended without a demonstrated need and a plan for appropriate monitoring. Warning: Risks associated with extended-release opioid medications (for example, hydrocodone-only extended release medications) can be more dangerous than immediate-release opioids. This is also true for medications that are manufactured in an “abuse-deterrent” form. No drug at any dose or in any form is entirely safe. I understand that a “morphine equivalent dose” is the dose of morphine that I would need to take in order to equal the potency of the non-morphine opioid that I am prescribed, and I acknowledge that if my prescribing clinician elects to provide or continue providing opioid therapy at a morphine equivalent dose of more than sixty (60) milligrams per day, my risks associated with opioid therapy (including my risk of dying) are substantially higher.

Patient initials __________________

ALCOHOL: I am aware that I must not consume alcoholic beverages while taking these medications. Additionally, I understand that I must not use prescription or non-prescription medications containing alcohol while taking these pain medications. This is especially true if I am taking extended-release opioid (morphine-like) drugs. Consumption of alcohol while taking these medications may result in the rapid release and absorption of a potentially fatal dose of medication. I will notify my prescriber the true nature and extent of any alcohol that I consume.

ADDICTION: I am aware that addiction can be defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug for non-medical purposes, and preoccupation with obtaining the drug. I understand that addiction is a life-threatening condition that may have no cure. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

PHYSICIAL DEPENDENCE: I understand that physical dependence is a common and expected result of using these medicines. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my medicine dose is markedly decreased, stopped or reversed by some other drug (such as naloxone's effect on reversing opioids), I will likely experience a withdrawal syndrome. In the case of opioid withdrawal my symptoms could include 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, and worsening of my usual pain. I am aware that opioid withdrawal is uncomfortable and possibly life threatening, especially with benzodiazepines. I also understand that the withdrawal from other drugs such as sedatives and anticonvulsants can be life threatening.

TOLERANCE: I am aware that tolerance to pain care means that I may require more medicine to get the same amount of pain relief. If this occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

SECURITY OF MEDICATIONS: I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. I will keep my medications locked, secure, and under my control at all times. I will never allow children (or pets or other animals) access to my medications, as this could result in tragic deadly outcomes. I understand that there are people willing to risk their own lives or harm me in order to take these medications from me. I am expected to protect my medications. If my medication is stolen. I may be required to report this to my local police department and obtain a stolen item report. I will report the stolen or lost medication to my physician and, if asked, will complete a Lost/Stolen report. I agree that if my medications are lost, misplaced, stolen, or if I use them up sooner than prescribed, my prescriber may choose not to replace my medications. I understand that this can lead to a medication withdrawal syndrome that could be life threatening, and therefore I will seek medical attention in the event that I have any withdrawal symptoms.

FOLLOWING DIRECTIONS: Unless directed to by my prescriber, I will not alter my medication in any way, and I will take my medication as instructed and as prescribed by my licensed prescriber. My medication will not be broken, chewed, crushed, injected, snorted, or taken in any way other than how it is prescribed. I am responsible for my opioid medications. I will not allow my medications to be damaged. I am responsible for keeping track of the amount remaining from each prescription. In the case that a licensed provider other than my prescriber advises a change in how I take my medications, I will notify my prescriber (i.e., at Murphy Pain Center) immediately. I understand that a controlled substance used to treat an acute medical complaint is for time-limited use. I will discontinue the use of the controlled substance when the condition requiring the controlled substance use has resolved. I will not use any illicit substances such as cocaine, marijuana, etc. I understand that the use of alcohol together with opioid medications is dangerous and can lead to death.

PREGNANCY: I acknowledge that there are risks to a fetus when the mother has been taking opioids while pregnant - including the risk of fetal opioid dependency and neonatal abstinence syndrome. If I plan to become pregnant, become pregnant, or am suspicious that I am pregnant, I will notify my prescriber immediately, notify my obstetric doctor immediately and contact Murphy Pain Center to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will likely be physically dependent on the medicine. I understand that birth defects can occur whether or not a mother is on medicines, and there is the possibility that my baby will have a birth defect while I am taking a medication such as an opioid. I understand that I may be on other medications, such as sedatives that may carry a higher risk of birth defects than opioids. I understand that any medication may cause harm to my embryo/fetus/baby and hold Murphy Pain Center prescribers and staff harmless for injuries to the embryo/fetus/baby.

Patient initials __________________

KEEPING APPOINTMENTS: It is my responsibility to schedule appointments for the next refill of medications. I will communicate fully and honestly with my prescriber about my pain level and my activities. If I must reschedule, I will notify Murphy Pain Center prior to my scheduled time, and I understand that I may responsible for reschedule, cancellation or no-show fees. I know that immediate or emergency appointments to address medication issues may not be available. However, I understand that I am allowed to seek the services of another healthcare provider in the event of an emergency or acute situation. Refills are expected to be authorized at planned in-person clinic visits or at telecommunication visits in accordance with government regulations. I will not expect any medications will be prescribed during the evening or on weekends. I do not expect prescriptions to be authorized in advance due to vacations, meetings or other commitments. I understand that the policy is for all controlled substance prescriptions to be electronically prescribed directly to the pharmacy. I give Murphy Pain Center full permission to communicate with any pharmacy about my medical care and medications.

DRUG TESTING AND PILL COUNTS: My prescriber may perform drug testing and random (unannounced) pill counts. I agree that I may be called at any time to come in to the clinic for a count of all my remaining medications and/or a drug screen and I agree to comply with the request. I agree to be responsible for any costs this may incur. If I do not submit to the requested drug test or pill count, I understand that my prescriber may change my treatment plan, and this might include tapering, changing, or discontinuing my medications and/or termination of our patient-prescriber relationship. I will inform Murphy Pain Center (and all of my other healthcare providers) of all medications I am taking, including herbal remedies. I further understand that medications, including over-the-counter non-prescription medications can interact with opioid medications and can be dangerous. The presence of a non-prescribed drug or illicit drug in my drug screen may be cause for termination of our relationship.

SHARING INFORMATION: I agree to allow my healthcare provider to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions if the he or she feels it is necessary. I consent to and authorized Murphy Pain Center to obtain and receive information from any health care provider or pharmacist about use or possible misuse of any medications, alcohol, or other drugs. Furthermore, I consent to and authorized Murphy Pain Center to contact my family and/or friends to monitor my conditions. And I consent to a criminal background check.

PRIMARY CARE PROVIDER RELATIONSHIP: I will maintain a relationship with a primary care provider and keep this provider informed of all medications I am taking and of all treatments provided by Murphy Pain Center. I agree have an annual preventive health screening and physical exam by my primary care provider. If recommended, I will see a specialist and/or complete a screening exam to help determine whether I am developing an addiction or psychological illness. I agree to be responsible for any costs this may incur.

FUNCTIONAL GOALS: I understand that the main treatment goals are to improve my quality of life and ability to function. I understand that it may be unrealistic for me to expect complete resolution of my pain with any specific treatment or combination of therapies. I understand that it is important to have a conversation with my provider about my treatment plan and set realistic goals for improvement. I pledge to work with my provider towards improving my pain control and achieving specific functional goals. I understand that functional goals might include increasing physical activity level, resuming a job/hobby, daily household chores, or improving the quality of sleep.

AN “EXIT STRATEGY”: I agree that if any of the following goals are not attained this may be evidence of a failure of opioid therapy and discontinuation of some or all of my medications could be the most appropriate plan: (**1**) meaningful pain control; or (**2**) acceptable level of function; or (**3**) tolerable side- effects; or (**4**) stable and acceptable mental health and behavior; (**5**) compliance the plan of care, laws, and regulations, (6) or failure to cooperate with Murphy Pain Center in any treatment, payment and other health care operation performed in conjunction with my care.

OFF-LABEL USE of MEDICATION: All prescription drugs in the US have a label approved by the FDA. This label provides an indication and dosage for the drug, but neither physician nor patient is legally bound to follow them. Studies cannot reliably evaluate all the combination treatments in complicated, difficult-to-treat conditions. **I understand that my treatment may include “off label” use of medications.**

Patient initials ___________________

BUPRENORPHINE: In the event that I am prescribed buprenorphine (or buprenorphine/naloxone) as a medication for a diagnosis of opioid use disorder, I understand that mixing buprenorphine/naloxone with other medications, especially benzodiazepines (sedatives or tranquilizers) and/or other drugs of abuse including alcohol, can be dangerous. Also, use of buprenorphine/naloxone by a person who is physically dependent on (or currently using) opiates will produce severe opiate withdrawal. I have been informed that buprenorphine is an opioid, and thus it can produce a "high." I know that taking buprenorphine/naloxone regularly can lead to physical dependence and addiction, and that if I were to abruptly stop taking buprenorphine/naloxone after a period of regular use, I could experience symptoms of opiate withdrawal. I have been informed that buprenorphine/naloxone is a powerful drug and that supplies of it must be protected from theft or unauthorized use, since persons who want to get high by using it or who want to sell it for profit, may be motivated to steal it from me. I understand that medication management of addiction with buprenorphine is only one potential component of the treatment of addiction and is best utilized in conjunction with other non-pharmaceutical treatments, such as behavioral counseling, 12-step programs, other meetings and groups, and social services.

PATIENT EDUCATION: I acknowledge that I have been educated on the following matters through verbal or written counseling: (1) proper use; (2) impact on driving and work safety; (3) effect of use during pregnancy; (4) potential for overdose and appropriate response to overdose; (5) safe storage of controlled substances; and (6) proper disposal.

DISCONTINUATION OF TREATMENT: I understand that **my violation of any of the above conditions** may result in re-evaluation of my treatment plan and discontinuation of my medication. I could be gradually taken off these medications or even discharged from the clinic. If my violation involves obtaining controlled substances from another individual, as described above, I may also be reported to my physician, medical facilities and other authorities, including the police.

UNDERSTANDING: I have read this entire form or it has been read to me. I know I may have a copy of this form. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. I fully understand the consequences of violating this agreement. I have been explained the risks and potential benefits of these therapies, including, but not limited to, psychological addiction, physical dependence, withdrawal and over dosage. All of my questions regarding the treatment of pain with opioids and other controlled substances have been answered to my satisfaction. I understand that the success of my treatment depends on trust, honesty and understanding of how opioids and other controlled substances are utilized. I understand that violation of any part of this agreement may result in this medication being discontinued, as well as termination of my relationship with my provider. I know I may have a copy of this form. I voluntarily give my consent for treatment of my medical condition with opioids and other controlled substances.

Patient signature: ____ **Date:** ___________________

Patient name (print): ____

JPM 2/25/2021