Twin Cities Pain Clinic

7235 Ohms Ln, Edina, MN 55439

Tel: (952) 841-2345
Fax: (952) 841-2346
twincitiespainclinic.com

Consent for Chronic Opioid Therapy

I understand that the use of opioid medications has possible risks and potential side effects, including but not limited to: drowsiness, constipation, nausea, vomiting, itching, dizziness, slowing of breath rate, slowing of reflexes or reaction time, allergic reaction, tolerance, physical dependence, and addiction. I understand the medication will not provide complete pain relief. These possible side effects make certain activities dangerous to me or others, including but not limited to: driving, operating heavy equipment, working at unprotected heights, or being responsible for another individual.

I understand that chronic opioid therapy has been associated with not only addiction and abuse, but also multiple medical problems, including but not limited to: the suppression of endocrine function resulting in low hormonal levels which may affect mood, stamina, sexual desire, and physical and sexual performance.

I understand that long-term and/or high doses of opioid medications may also increase levels of pain, known as opioid-induced hyperalgesia. This is only treated by stopping opioids.

I understand that physical dependence is not the same as addiction. Physical dependence is a normal, expected result of using these medications for a long time. I am aware that physical dependence means that if pain medication is suddenly decreased or stopped, I will experience withdrawal symptoms, including: runny nose, yawning, large pupils, goose bumps, nausea, vomiting, diarrhea, body aches, irritability, and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable, and in certain cases, could even result in heart attack, stroke, or death.

I understand that tolerance to opioid medications means that I require more medication to get the same pain relief. If it occurs, increasing doses does not always help and may cause unacceptable side effects. Tolerance to opioids may cause my provider to choose another treatment.

For female patients: If I become pregnant while taking opioid medications, I am aware that, should I carry the baby to delivery while taking these medications, the baby will be physically dependent upon opioids. I agree to notify TCPC if I plan to become pregnant. If I become pregnant, I agree to immediately call my obstetrician and TCPC to inform them. I will not stop these medications without discussing it with my provider first, as sudden discontinuation of the medication can result in miscarriage. I am also aware that opioids may cause a birth defect, even though it is rare.

I have read this consent form, and understand all of it. All of my questions have been answered. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid medications.

_____ _____

Patient Name (Printed) **Date of Birth**

_____ _____

Patient Signature **Date**

_____

TCPC Provider/Nurse/MA Signature

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Controlled Medication Agreement

Controlled medications are strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and your provider by establishing guidelines, within the laws, for proper controlled substance use.

Name:_____ **DOB:**_____

1. The medication must be safe and effective and help me to function better, at the lowest dose. If my activity level or function gets worse, the medication will be changed or discontinued.
2. I will participate in other treatments (physical therapy, psychology, etc.) that my provider recommends and will be ready to decrease or discontinue the medication as other effective treatments become available.
3. I will take my medications exactly as prescribed. I will not change the medication dosage or schedule without my provider's approval. I understand that taking more than is prescribed will result in my being without medication for a period of time which may cause me to go through withdrawal.
4. I will return for an appointment BEFORE running out of medication. I will bring all unused pain medication to every office visit in its original bottle to be counted. I understand a pill count is required at EVERY office visit.
5. I understand that I will occasionally be required to return to the clinic for a pill count in between appointments. I understand that I must come in to the clinic within 24 hours of the request and bring my unused pain medication to be counted.
6. I will keep regular appointments as determined by my provider. I agree that prescription refills or changes to my pain medications will be made only at the time of an office visit. No refills or changes will be available during evenings or weekends.
7. One provider – All pain medications must be prescribed by a provider at TCPC. I will not obtain pain medications from any provider outside of TCPC. I will tell any outside providers/hospitals/emergency rooms that I receive pain medications from TCPC. Acute injuries/conditions (ie. fractures, dental procedures) and scheduled surgeries require approval from TCPC prior to receiving pain medication. It is my responsibility to notify TCPC and obtain this approval before accepting any pain medication and/or prescriptions for pain medication.
8. One pharmacy – I will choose one pharmacy where all my prescriptions will be filled.

   Pharmacy: _____ **Location:**_____ **Phone:** _____

9. I will safeguard my medication/prescriptions from loss, theft, destruction, or unintentional use by others. I understand these will not be replaced. Early refills will not be permitted.
10. I will not use illegal/recreational drugs, including marijuana.
11. I will abstain from alcohol while this agreement is active, regardless of my opioid dose.
12. I will not share my medication with anyone or use medications prescribed to other people.
13. I will provide urine and blood specimens at the provider's request to monitor my compliance. I understand these samples must be provided at the time of the request.
14. I understand that driving while under the influence of any substance which impairs my driving ability (including opioid medications), may result in DUI charges.

15. I understand that my health information may be exchanged with other providers, pharmacists, and drug/law enforcement agencies to assist in my treatment and maintain accountability. I understand my provider will be verifying my prescription history through the Prescription Monitoring Program.
16. I understand that clinic staff (nurses, receptionists, lab staff, etc.) are very important in my success with this treatment plan. I will treat them respectfully and abide by their enforcement of this agreement.
17. I understand that if I fail to follow the above items, my provider will stop prescribing these pain medications to me. In this case, my provider will taper off the medication over a period of several days, and/or a chemical dependency program will be recommended.
18. If there is an urgent issue that cannot wait until the next business day, I will call (612) 999-5683 to leave a message for the on-call provider. If there is a life-threatening emergency, I will call 911.

I have read this agreement, and understand and accept all of its terms. I have been provided with a copy of this document. I have read and signed TCPC's "Consent for Chronic Opioid Therapy".

_____

Patient Name (Printed)

_____

Patient Signature

_____

Date

_____

TCPC Provider/Nurse/MA Signature

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10. I will not use illegal/recreational drugs, including marijuana. I will not share my medication with anyone or use medications prescribed to other people. I will provide urine and blood specimens at the provider's request to monitor my compliance. I understand these samples must be provided at the time of the request.
11. I will not consume Alcohol while taking any opioid medication as doing so may result in complications such as confusion, anxiety, respiratory depression, coma, and death.
12. I understand that driving while under the influence of any substance which impairs my driving ability (including opioid medications), may result in DUI charges.
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