PAIN MANAGEMENT AGREEMENT / DRUG CONTRACT

Dr. Boos is prescribing opioid medicine (narcotic analgesics) to _____.
Pain management treatment sometimes requires the usage of narcotic pain medication for a legitimate medical purpose. The decision was made to use these medicines because my condition is chronic or other treatments have not helped my pain. Controlled substances (i.e. Narcotics, Tranquilizers, and Barbiturates) are very useful, but have a high potential for misuse and are therefore closely controlled by the local, state, and federal government. The goals of this agreement are to ensure you understand and agree to follow the rules regarding controlled pharmaceuticals. I understand that this Agreement affects the doctor/patient relationship and that my doctor may stop prescribing these pain control medicines if the terms of the Agreement are broken. I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness/drowsiness, constipation, nausea/vomiting, itching, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and the possibility that the medicine will not provide complete pain relief. By voluntarily signing this consent I am agreeing to the following conditions as long as I am a patient at Central Arkansas Pain Center:

I will tell my doctor about all other medicines or treatments that I am receiving from other physicians.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not request or accept any opioid medication or controlled substance from a physician or individual other than Dr. Boos, so long as I am under his care. I understand that I will be immediately discharged from this practice, if it is determined that I accepted opioid or other habit forming medications from other health care providers or individuals. The only exception is if I am admitted to the hospital in an emergency.

I will not use any illegal controlled substances (including marijuana, cocaine, heroin or other illegal substances).

I understand that I am responsible for my prescription. I understand that PRESCRIPTION REFILLS:

1. Can only be written for a one (1) month supply

2. Will be given during regular office hours, Monday through Thursday. Prescriptions **will not** be given on holidays or after hours.

3. Must be picked up in person. No one else will be allowed to pick up your prescription.

4. Must keep scheduled appointments / medical evaluation / follow up or I will no longer receive medication refills. I agree to keep all appointments.

5. Will notify the office at least three (3) business days in advance of my need for a refill.

6. Will not be given if I "run out early, "lose my prescription" or "spill or misplace my medication". I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.

If my medication is stolen, I will report this to my local police department and obtain a stolen item report. Replacement prescriptions will be given at the discretion of my physician. I **MUST** safeguard my medicine.

Will not share, sell, or trade my medication with anyone. I will bring all unused pain medicines to every visit. I will never discard pain medicines myself , I will bring them to the office where they will be destroyed. The medication is for **my use only. I will never give the medication to others.**

I agree to take the medication only as prescribed. I understand that increasing my dose without the close supervision of my physician can lead to drug overdose causing severe sedation, respiratory depression and death. I understand that decreasing or stopping this medication with the close supervision of my physician can lead to withdrawal. **WITHDRAWAL SYMPTOMS** may include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh", abdominal cramps and diarrhea. These symptoms can occur 24 to 48 hours after the last dose and can last up to three (3) weeks.

I agree to use ONLY the following pharmacy for filling prescriptions of all my controlled medicines:

_____

I authorize the doctor and my pharmacy to cooperate with any city, state, or federal law enforcement agency, or Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of the Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I authorize the release of any information and hospital records by my physician or his designate to other healthcare providers, my family, my employer, my insurance company, and other reimbursing agencies. I also authorize any pharmacy to release information regarding my prescriptions.

I agree to comply with random urine, blood, and/or breath testing to document the proper use of my medications as well as to confirm compliance.

I will bring twenty dollars cash ($20.00) to each visit in the event of a random drug screen.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: operating heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for him/herself. I understand that driving a motor vehicle may not be allowed at times while taking controlled substances and that it is my responsibility to comply with the laws of this state while doing so.

I understand that it may be deemed necessary by my doctor for me to see a medication use specialist at any time I am receiving Controlled Substance medication. I understand if I do not attend this appointment that my medications may be discontinued, or refilled at a tapering dose to completion. I understand that if this specialist feels I am at risk for psychological dependence my medications will no longer be filled.

I understand that certain other medicines such as Nalbuphine (Nubain), Pentazocine (Talwin), buprenorphine (Buprenex), and Butorphanol (Stadol) may reverse the action of the medicine I am using for pain control. Taking any of these medicines while I am taking my pain medicines can cause withdrawal syndrome which can make me feel as if I have a bad flu. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and can't take any of the medicines listed above.

I understand that many drugs may interact with opioids, with possible serious side effects. Common medications which frequently cause such interactions include: tranquilizers such as Diazepam (Valium), Alprazolam (Xanax), and Lorazepam (Ativan); sedatives such as Dalmane; muscle relaxants such as Soma, Flexeril and Fiorinal; antihistamines such as Benadryl; and alcohol. Side effects from drug interactions include profound sedation, respiratory depression, blood pressure drop, and even death. Many other medications also interact with opioids. I agree to ask ANY physician about the possibility of drug interaction with opioids whenever ANY new medication is prescribed.

I understand that SIDE EFFECTS may occur with opioid medication. Common side effects are nausea and vomiting (similar to motion sickness), drowsiness and constipation. (I understand that daily laxative use is often necessary.) Less common side effects are mental slowing, flushing, sweating, itching, urinary difficulty and jerking muscles. These side effects may occur at the beginning of my treatment and often go away within a few days without treatment. It is my responsibility to notify my physician for any side effects that are severe (e.g., sedation, confusion).

I understand that physical dependence is to be expected after long term use of opioids. Physical dependence is common to many drugs used to treat blood pressure, epilepsy, and chronic pain. Dependence means that chemical changes in the brain have occurred in response to medication therapy. I understand that if I abruptly stop a medication on which I am dependent, I will cause a withdrawal syndrome. I understand that physical dependence is a normal, expected result of using medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware that opioid withdrawal is uncomfortable but not life threatening. When I stop a medication I must do so slowly and under medical supervision.

Addiction is different than physical dependence. Addiction is a psychological and behavioral syndrome that is recognized when a person used a drug to obtain mental numbness or euphoria, or when a person shows drug-craving behavior. Addiction is suspected when a person goes "doctor shopping", when the drug dose is quickly escalated without correlation to pain relief, and/or when a patient shows a manipulative attitude toward a physician in order to obtain the drug. If I begin to exhibit such behavior, I understand that opioid medication will be tapered and discontinued. I am aware that addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge

I understand that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur with me. I understand that if it occurs, increasing my medicine dose does 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. If it appears to my physician that there is no improvement to my daily function or quality of life from the controlled substance, my opioid medication may be discontinued. I will gradually taper my medication as prescribed by my physician.

I understand that opioid medications may be used alone or in conjunction with other pain modalities such as nerve blocks and spinal injections.

MALES ONLY - I understand chronic opioid use has been associated with low testosterone levels. This may affect my mood, stamina, sexual desire and physical and sexual performance. I agree my doctor may order lab tests to check my testosterone level.

FEMALES ONLY - I understand if I plan to become or have become pregnant while taking this pain medicine I will immediately call my obstetric physician and this office to inform us of this occurrence. I am aware that should I carry a baby to delivery while taking these medicines the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines. I am aware there is always the possibility that my child may have a birth defect while I am taking an opioid.

I understand that I can not hold the physician responsible for any harmful act which I may commit, any error in judgment, or any faulty legal decisions which may result from my controlled substance therapy.

I understand if I violate any of the above conditions my prescriptions / medications and / or treatment at Central Arkansas Pain Center I may be terminated **IMMEDIATELY**. I may also be reported to my physician, medical facilities, and other appropriate authorities.

I understand medication changes will only be made by the physician and will not be changed on refill appointments with the nurse practitioner. An appointment will need to be made with the doctor for any medication changes.

I agree to follow this plan. All of my questions and concerns have been adequately answered. I understand it all. By signing this form voluntarily, I give my consent for my treatment of my pain with opioid pain medicines. I also agree to allow Central Arkansas Pain Center to share any information in my chart with health care providers who have / will have treated me in the past, present, and those who may treat me in the future.

_____

Patient Signature Date

_____

Witness Signature Date

_____

Physician Signature Date