

Patient's Consent to Receive Opioid Therapy

I understand that Dr. _____ ("my physician") is recommending opioid medication to treat the pain I have due to my _____ (diagnosis).

I understand that opioid medication is being recommended because my pain complaints are moderate to severe and other treatments have not sufficiently helped my pain. I understand that many medications can have interactions with opioids that can either increase or decrease the opioid's effect on me.

I told my physician about all other medicines and treatments that I am receiving and I will promptly let my physician know if I start to take any new medications or have new treatments.

I told my physician about my complete personal drug history and that of my family.

It has been explained to me that the initiation of an opioid medication is a trial. Continuation of the medication is based on evidence of benefit to me, a lack of harmful side effects, and me following instructions on the usage of the medication. Continuation and any changes in dosage of the opioid medication will be determined by my doctor based on pain relief, functional improvement, side effects, and me following instructions for its usage. If I have a lack of significant improvement, the development of harmful side effects, or other considerations, my physician may stop using this treatment or change dosage.

It has been explained to me that taking narcotic/opioid medication may pose certain **risks and side effects** to me. These **risks and side effects** include, but are not limited to, the following:

- Allergic reactions
- Overdose (which could result in harm or even death)
- Slowing of breathing rate
- Slowing of reflexes or reaction time
- Sleepiness, drowsiness, dizziness, and/or confusion
- Impaired judgment and inability to operate machines or drive motor vehicles
- Nausea, vomiting, and/or constipation
- Itching
- Physical dependence or tolerance to the pain relieving properties of the medication (This means that if my medication is stopped, reduced in dose, or rendered less effective by other medications I may be taking, I may experience runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. These can be very painful but are generally not life-threatening)
- Addiction
- Failure to provide pain relief
- Changes in sexual function (This is generally caused by reduced testosterone levels. Such reduced levels may affect mood, stamina, sexual desire and physical and sexual performance)
- Changes in hormonal levels
- Certain other medicines such as nalbuphine (Nubain™), pentazocine (Talwin™), buprenorphine (Buprenex™), and butorphanol (Stadol™), may reverse the action of the opioid and may cause symptoms like a bad flu, called a withdrawal syndrome
- Dangers to others if they get access to opioids including overdose, addiction, or even death

For Women of Childbearing Age Only (under Tennessee law, ages 15 – 44):

Risks associated with opioid use during pregnancy

It has been explained to me that the use of narcotic/opioid medication poses special risks to women who are pregnant or may become pregnant. I have been advised, for example, that should I carry a baby to delivery while taking this medication, **the baby will be physically dependent on opioids** (called “neonatal abstinence syndrome”), which is very harmful to the baby. I also understand that **birth defects** can occur to the baby whether or not the mother is on medications and there is always the possibility that my baby will develop a birth defect while I am taking an opioid. Furthermore, I recognize that the long-term consequence on a child’s development who was exposed to opioids is not fully understood and cannot be predicted, but it could be harmful to the child.

It has been explained to me that there are other treatments that do not involve use of narcotic/opioid medications. I have had an opportunity to discuss these options with my physician and to ask questions about them which have all been answered to my satisfaction.

Birth control counseling

It has been explained to me my options for birth control to reduce the chances that I become pregnant while being treated with narcotic/opioid medication. I have been counseled on appropriate and effective forms of birth control. I have also received information about how I can receive free or reduced cost birth control.

Initials of patient acknowledgement: _____

Signature of parent/legal guardian if parent/legal guardian of a minor patient was given this advisory instead of the minor patient or if parent/legal guardian is otherwise required to provide informed consent for this patient: _____

Note: Nothing prohibits a physician from advising, counseling or providing information directly to a competent and mature minor patient. (TCA 53-11-308).

Patient Consent

Having been informed of the risks and potential benefits both of opioid medications and possible alternative treatments, having had the characteristics, expectations and how opioids should be used and having been given the opportunity to discuss options and ask any questions that I may have, I agree that any questions that I have raised have been discussed to my satisfaction. Therefore, **I voluntarily consent to take opioid medication.**

If I plan to become pregnant or believe that I have become pregnant while taking opioid medication, I will immediately call my obstetrician and this office to inform them.

I will take this opioid medication only as prescribed and I will not change the amount or dosage frequency without authorization from my physician. I further understand that changes may result in my running out of medications early, and early refills may not be allowed. I also understand that if I do not take the

medication correctly, I may have withdrawal reactions that may include stomach pain, sweating, anxiety, nausea, vomiting and general discomfort.

I agree not to take nalbuphine (Nubain™), pentazocine (Talwin™), buprenorphine (Buprenex™), and butorphanol (Stadol™), while I am taking an opioid and I further agree to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed here.

I will obtain my opioid prescriptions from my physician or, during his or her absence, by the covering physician. Requests for pain medications from the on-call physician (nights and weekends) will not be honored.

I will fill opioid medication prescriptions at only one pharmacy. I will notify my physician if I change pharmacies. I hereby authorize my physician to discuss all diagnostic and treatment details of my condition with the pharmacists at the dispensing pharmacy. The pharmacy that I have selected is: _____ . Its phone number is: _____ .

I will submit to random pill counts and urine and/or blood drug tests as requested by my physician in order to monitor my treatment. I understand that the presence of any unauthorized substances in my urine or blood may prompt referral for assessment of addiction or chemical dependency and could result in discontinuation of further opioid prescriptions. I also understand that failure to follow these rules may lead to my no longer being treated by my physician after a 30-day, emergency-only period.

I will not share, sell, or otherwise permit others to have access to this medication and I will keep it in a secure location.

I HAVE READ THIS FORM OR HAD IT READ TO ME. I UNDERSTAND ALL OF IT. I HAVE HAD A CHANCE TO HAVE ALL OF MY QUESTIONS REGARDING THIS TREATMENT ANSWERED TO MY SATISFACTION. BY SIGNING THIS FORM, I VOLUNTARILY GIVE MY CONSENT FOR THE TREATMENT OF MY PAIN WITH OPIOID PAIN MEDICINE. I UNDERSTAND AND AGREE THAT FAILURE TO FOLLOW THESE POLICIES WILL BE CONSIDERED NONCOMPLIANCE AND MAY RESULT IN STOPPING OPIOID PRESCRIBING BY MY PHYSICIAN AND POSSIBLE DISMISSAL FROM CARE BY THIS CLINIC.

Patient or Parent/Guardian Signature

Date: _____

Patient or other signatory's name printed