GRANITE STATE PAIN ASSOCIATES

GRANITE STATE SURGICENTER

www.PainMD.com

Controlled Substance Informed Consent-Agreement

Name: _____ **Date of Birth:** _____

Please Check All Items: I understand and agree that:

☐ 1. The goal of opioid/controlled medication therapy is to reduce pain, improve function, improve ability to engage in work, social recreation and/or physical activities and improve quality of life.

☐ 2. Opioid/controlled medications may be continued as long as:
- There is acceptable improvement in/maintenance of level of pain and function
- Medications are used according to prescription /provider orders
- I participate in other therapies such as PT, exercise, non-opioids medications, and keep appointments
- There are no significant, unmanageable side effects

☐ 3. GSPA/GSSC seeks to prescribe controlled substances according to current guidelines, respecting maximum suggested dosing. I agree to weaning/tapering to the lowest possible dose and duration.

☐ 4. There are risks/side effects involved with opioid/controlled medications, including, but not limited to the following:
- Physical side effects - include mood changes, drowsiness, sedation, nausea, constipation, bowel obstruction, urination difficulties, depressed breathing, itching, altered appetite, allergic reactions, death, coordination problems, personality changes, bone thinning, sexual difficulties, such as lowering of male hormone in men and cessation of menstrual periods in women, and sleep apnea (periods of not breathing while asleep).
- Physical dependence – (Habituation) Sudden stopping or rapid decrease of dose of an opioid may lead to withdrawal symptoms including abdominal cramping, pain, diarrhea, sweating, anxiety, irritability and aching.
- Tolerance – A dose of an opioid may become less effective, requiring more medication over time even though there is no change in my physical condition. If this happens, my medication may need to be changed or discontinued.
- Addiction – (Psychological Addiction) Is more common in people with personal or family history of addiction, but can occur in anyone. It is suggested by drug craving, loss of control and poor outcomes of use.
- Hyperalgesia- Increased sensitivity to and/or increasing experience/perception of pain caused by the use of opioids may require change or discontinuation of medication.
- Overdose – Taking more than the prescribed amount of medication or using with alcohol or other drugs can cause you to stop breathing resulting in coma, brain damage, or even death.
- Victimization – There is a risk that you or your household may be subject to theft, deceit, assault or abuse by persons seeking to obtain your medications for purposes of misuse.
- Life-threatening irregular heartbeat – Can occur with methadone and buprenorphine.

☐ 5. If I am having intolerable side effects to my pain medications, I stop the medication and immediately notify my provider.

☐ 6. Alcohol abuse and/or combining illegal substances with prescribed medication increases my risk of breathing difficulties, heart disorders, and sudden death. If I do so, I may be discharged from the practice or be asked to seek treatment at a drug rehab facility.

☐ **7. Driving is a risk when I use opioids/controlled substances. Safety is my responsibility. I will not drive, operate heavy equipment, or attempt to function in any capacity that might endanger me or the public.**

☐ 8. If I am a woman, I will notify my provider immediately if I become pregnant. To the best of my knowledge, I am not pregnant at this time nor am I trying to become pregnant. I understand that opioids are NOT recommended for use during pregnancy due to the potential for harm to the infant. Risks to unborn children may include: birth defects/infant withdrawal/physical dependence at birth, alterations in pain perception, increased risk for development of addiction. Babies born to women taking opioids often suffer withdrawal after birth requiring prolonged medical care in a specialized nursery unit. All women of childbearing age who are taking opioids and are not using a form of dependable birth control, are advised to discuss with their OB/GYN or primary care provider what methods might be appropriate for them. I also recognize that my provider will make decisions regarding my care based on what is best for the fetus in the event that I become pregnant. This decision may include decreasing, discontinuing, or changing my opioid to a potentially less harmful medication. I understand there is risk of miscarriage with all of these options.

☐ 9. If I fail to adhere, even once, to any of these agreement terms, my provider may decide to discontinue certain treatment or discharge me from the practice altogether. If discharged, a one-month prescription of medications and/or withdrawal meds may be prescribed. I will be given a list of other pain specialists to contact upon request. I understand that GSPA/GSSC is under no obligation whatsoever to treat me after 30 days from discharge, even if I cannot find another pain provider.

I have read, understand and will comply with this agreement. My questions have been answered.

Name _____

Signature _____ Date _____

2 copies given to patient One for patient, One for their Pharmacy

Controlled Substance Prescription Terms

Name: _____ **Date of Birth:** _____

Please Check All Items: I understand and agree that:

☐ 1. The providers at GSPA/GSSC will provide treatment and medications related to pain. I am to consult my primary care provider (PCP) for other non-pain-related medical issues. If medications for pain are prescribed by my PCP, dentist, ER doctor, or others, I will contact my GSPA/GSSC provider for permission BEFORE I fill the prescription or consume the medication. If the medication is administered in a true emergency situation, I will notify my GSPS/GSSA provider.

☐ 2. Regarding medication use:

- I will use my medications only as my provider prescribes them
- The provider must PRE-approve any dose adjustments.
- The provider is not required to prescribe additional medications should I run out of medication ahead of schedule.
- The provider is not obligated to seek prior authorization (PA) of medication.
- Alternative medications may be prescribed to ease the effects of withdrawal.
- N**ot taking my prescriptions as directed may result in my discharge from the practice.**
- I am to never use any medications prescribed to me to intentionally cause any harm to myself or others
- I will inform my provider of any changes in any other medications I am receiving, including holistic/herbals
- I will not sell, share, or trade my medication with anyone. It is a crime.
- I will never alter a prescription in ANY way. I understand this is a felony, punishable by incarceration.
- I agree not to take any other medications without prior permission from my provider. I understand that overdose deaths have occurred when other medications are taken with controlled substances.

☐ 3. Prescriptions are provided at appointments. Medications are generally not prescribed/adjusted over the phone. I must make an appointment to be seen in person. Providers are generally not available to prescribe medication during evenings, weekends, or after noon on Fridays. It is my responsibility to call the office at least **3 (three) *business* days** prior to running out of medications. I must provide a **viable contact number at all times** or my provider may not prescribe medications.

☐ 4. Upon my provider's request and as often as directed, I will submit my own urine specimen for drug screens and confirmations (narcotic, cannabis, cocaine, amphetamine, PCP, alcohol, benzodiazepine, and others). My provider may ask that a clinical staff member observe me providing the appropriate specimen. If the report indicates the presence of illegal or otherwise inappropriate substances, I may be discharged or required to seek treatment at a drug rehab facility.

☐ 5. I will be required at any time with short notice to bring in my medication for inspection and counting. If I do not show or do not have the appropriate amount of medication, I may be discharged. I am not to dispose of medication myself without a staff member as an observer.

☐ 6. I will safeguard/secure/lock my written prescriptions and medications to prevent loss, damage or theft. I need to prevent use or diversion by others. My provider will not replace lost or stolen prescriptions or medication and may choose to discharge me from the practice. Damaged prescriptions may be replaced at the pain provider's discretion.

☐ 7. I authorize GSPA/GSSC to cooperate fully with any city, state, or federal law enforcement agency, including New Hampshire's Board of Pharmacy and the DEA, in the investigation of any possible misuse, prescription forgery, sale or any other diversion of my pain medication.

☐ 8. If I am receiving intrathecal drug system administration, I understand the importance of keeping my scheduled pump refill appointments. I understand in the event that my insurance policy will not pay for the medication that I am responsible for paying for my pump medication at the time of refill. I understand that if my pump is not refilled when it is running empty that I risk going through withdrawal and that I risk my health and life if that occurs. I understand the importance of notifying my provider if I hear my pump beeping that it is near to running empty. I accept the responsibility if I allow my pump to run empty.

☐ 9. I allow my provider to receive information from/communicate with any pharmacy I have used. As per DEA guidelines, the NH Prescription Drug Monitoring Program is regularly reviewed for my prescriptions (current and history).

☐ 10. If I fail to adhere, even once, to any of these contract terms that my provider may decide to discontinue certain treatment or discharge me from the practice altogether. If discharged, one month's supply of current pain medications and/or anti withdrawal meds may be prescribed, and I will be given a list of other pain specialists to contact upon request. I understand that GSPA/GSSC is under no obligation whatsoever to treat me after 30 days from discharge, even if I cannot find another pain provider.

I will have all my medications filled <u>only</u> at the pharmacy I have listed below. I will inform my provider of any pharmacy changes. I have read, understand and will comply with this agreement. My questions have been answered.

Name _____

Pharmacy _____ Town _____ Phone _____

Signature _____ Date _____

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