

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 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

Controlled Medication Agreement for Intrathecal Pain Pumps

Controlled medications are strictly regulated by 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 keep regular appointments as determined by my provider. It is my responsibility to return BEFORE my pump alarm date.
4. One provider – All pain medications must be prescribed by a provider at TCPC. I will not obtain pain medications from any other provider without prior approval from TCPC. I will tell any hospital/emergency room that I have a pain pump. I will notify TCPC in advance for approval of pain medications recommended for acute injuries/conditions (dental procedures, surgery, etc.).
5. I will not use alcohol or illegal/recreational drugs, including marijuana. I will not use medications prescribed to other people. I will provide urine and blood specimens at the provider's request to monitor my compliance.
6. I understand that driving while under the influence of any substance which impairs my driving ability (including opioid medications), may result in DUI charges.
7. 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.
8. 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.
9. I understand that if I break this agreement, TCPC will stop managing my pump. In this case, my provider will taper off the medication and/or a chemical dependency program will be recommended.
10. 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 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

Controlled Medication Agreement for Intrathecal Pain Pumps PATIENT COPY

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HEALTH ASSESSMENT QUESTIONNAIRE (HAQ-DI)©

Name: _____

Date: _____

Please place an "x" in the box which best describes your abilities OVER THE PAST WEEK:

	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
<u>DRESSING & GROOMING</u>				
Are you able to:				
Dress yourself, including shoelaces and buttons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shampoo your hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>ARISING</u>				
Are you able to:				
Stand up from a straight chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get in and out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>EATING</u>				
Are you able to:				
Cut your own meat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lift a full cup or glass to your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open a new milk carton?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>WALKING</u>				
Are you able to:				
Walk outdoors on flat ground?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb up five steps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check any AIDS OR DEVICES that you usually use for any of the above activities:

<input type="checkbox"/> Devices used for Dressing (button hook, zipper pull, etc.)	<input type="checkbox"/> Built up or special utensils	<input type="checkbox"/> Crutches
<input type="checkbox"/> Special or built up chair	<input type="checkbox"/> Cane	<input type="checkbox"/> Wheelchair
	<input type="checkbox"/> Walker	

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

<input type="checkbox"/> Dressing and grooming	<input type="checkbox"/> Arising	<input type="checkbox"/> Eating	<input type="checkbox"/> Walking
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Please place an "x" in the box which best describes your abilities OVER THE PAST WEEK:

	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
<u>HYGIENE</u>				
Are you able to:				
Wash and dry your body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Take a tub bath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get on and off the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REACH

Are you able to:				
Reach and get down a 5 pound object (such as a bag of sugar) from above your head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend down to pick up clothing from the floor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GRIP

Are you able to:				
Open car doors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open previously opened jars?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turn faucets on and off?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ACTIVITIES

Are you able to:				
Run errands and shop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get in and out of a car?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do chores such as vacuuming or yard work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check any AIDS OR DEVICES that you usually use for any of the above activities:

<input type="checkbox"/> Raised toilet seat	<input type="checkbox"/> Bathtub bar	<input type="checkbox"/> Long-handled appliances for reach
<input type="checkbox"/> Bathtub seat	<input type="checkbox"/> Long-handled appliances in bathroom	<input type="checkbox"/> Jar opener (for jars previously opened)

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

<input type="checkbox"/> Hygiene	<input type="checkbox"/> Reach	<input type="checkbox"/> Gripping and opening things	<input type="checkbox"/> Errands and chores
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Your ACTIVITIES: To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

COMPLETELY

MOSTLY

MODERATELY

A LITTLE

NOT AT ALL

Your PAIN: How much pain have you had IN THE PAST WEEK?

On a scale of 0 to 100 (where zero represents “no pain” and 100 represents “severe pain”), please record the number below.

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Your HEALTH: Please rate how well you are doing on a scale of 0 to 100 (0 represents “very well” and 100 represents “very poor” health), please record the number below.

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