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 medication 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 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

Twin Cities Pain Clinic

7235 Ohms Ln, Edina, MN 55439

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

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 and 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 bring all unused pain medication to every office visit in its original bottle. I will return for an appointment **BEFORE** running out of medication. I understand a pill count is required at each office visit.

5. 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.

6. 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.

7. One pharmacy – I will choose one pharmacy where all my prescriptions will be filled.
Pharmacy: _____ Location: _____ Phone: _____

8. 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.

Twin Cities Pain Clinic
7235 Ohms Ln, Edina, MN 55439
Tel: (952) 841-2345
Fax: (952) 841-2346
twincitiespainclinic.com

9. I will not use alcohol or 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.

10. I understand that driving while under the influence of any substance which impairs my driving ability (including opioid medications), may result in DUI charges.

11. I understand taking pain medication and benzodiazepine medication is not advised due to the risk of respiratory depression, which could make me stop breathing.

12. 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.

13. 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.

14. I understand that if I break this agreement, 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.

15. 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

Twin Cities Pain Clinic

7235 Ohms Ln, Edina, MN 55439

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

Controlled Medication Agreement – ***Patient Copy***

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.

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 and 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 bring all unused pain medication to every office visit in its original bottle. I will return for an appointment BEFORE running out of medication. I understand a pill count is required at each office visit.
5. 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.
6. 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.
7. One pharmacy – I will choose one pharmacy where all my prescriptions will be filled.
Pharmacy: _____, Location: _____, Phone: _____
8. 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.
9. I will not use alcohol or 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.
10. I understand that driving while under the influence of any substance which impairs my driving ability (including opioid medications), may result in DUI charges.
11. I understand taking pain medication and benzodiazepine medication is not advised due to the risk of respiratory depression, which could make me stop breathing.
12. 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.
13. 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.
14. I understand that if I break this agreement, 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. 15. 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".

Twin Cities Pain Clinic

7235 Ohms Ln, Edina, MN 55439

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

Controlled Medication Agreement Quiz

This test verifies that you have read and understand the Controlled Medication Agreement that you signed in this packet. You may refer to the agreement to answer the questions. Circle True (T) or False (F) to best answer each question:

T / F 1. TCPC is prescribing me controlled medication to improve my functional level and may change or discontinue the medication if no improvement occurs.

T / F 2. Medication is only one component of my treatment plan and it is important that I participate in other treatments that TCPC recommends.

T / F 3. I should only take up to the maximum daily amount of controlled medication agreed upon with my provider at my most recent appointment.

T / F 4. If I am experiencing more pain, I can take more medication than is prescribed to me.

T / F 5. I do not need to bring in my medication to all appointments with my provider.

T / F 6. Regularly scheduled appointments are needed to assess my medications effectiveness and to receive prescriptions issued by TCPC providers.

T / F 7. If I am having surgery, have another condition that requires controlled medication, or am hospitalized for any reason, I will let TCPC know in advance to clarify and approve pain management from an outside provider.

T / F 8. Other providers may prescribe controlled medication to me and I may fill at any pharmacy.

T / F 9. TCPC replaces lost, stolen, or accidently destroyed medications.

T / F 10. I can drink alcohol while on controlled medications.

T / F 11. At every visit, I should be prepared to provide urine or blood samples to verify compliance.

T / F 12. I need to abstain from using illegal/recreational drugs, including marijuana, while on controlled medication.

T / F 13. I can call the on-call provider on the weekend to make changes in my medications.

T / F 14. If the agreement is broken, TCPC will continue to prescribe controlled medications to me.

T / F 15. If there is an urgent issue after hours that cannot wait until the next business day, I should call the on-call doctor.

Twin Cities Pain Clinic
7235 Ohms Ln, Edina, MN 55439
Tel: (952) 841-2345
Fax: (952) 841-2346
twincitiespainclinic.com

Risks of Combining Opioid and Benzodiazepine Medication

Common examples of opioid and benzodiazepine medication:

Opioids	Benzodiazepines
- Oxycodone/Percocet	- Alprazolam/Xanax
- Hydrocodone/Norco/Vicodin/Lortab	- Clonazepam/Klonopin
- Morphine	- Diazepam/Valium
- Fentanyl	- Lorazepam/Ativan
- Methadone	
- Oxycontin	
-Hydromorphone/Dilaudid	

Why is combining an opioid and a benzodiazepine dangerous?

When taken in combination these medications can easily lead to oversedation which may slow or stop your breathing leading to an accidental overdose. Oversedation symptoms may include confusion, drowsiness, lack of coordination which could lead to falls, lightheadedness, weakness, fainting, and/or memory loss. An accidental overdose could cause you to stop breathing, which could lead to organ failure, brain damage or death. The risk of accidental overdose can occur with any dose of medication, even if you have been taking the medication for a long time.

What to do if you are experiencing or someone notices oversedation or respiratory depression symptoms:

- Seek medical attention immediately if you are experiencing unusual dizziness or lightheadedness, extreme sleepiness, slowed or difficulty breathing, or you become unresponsive.

Talk to your healthcare provider if you have questions or concerns about taking opioid or benzodiazepine medications.

Twin Cities Pain Clinic
7235 Ohms Ln, Edina, MN 55439
Tel: (952) 841-2345
Fax: (952) 841-2346
twincitiespainclinic.com

Social History

Name: _____ Date of Birth: _____

1. Height: _____ Weight: _____

2. Is there a history of back pain or chronic pain problems in your family? ☐ Yes ☐ No
   a. If yes – who and what type? _____

3. Do you smoke? ☐ Yes ☐ No
   a. If yes – how many packs per day? _____

4. Do you drink alcohol? ☐ Yes ☐ No
   a. If yes – how much do you consume? _____ drinks per day/week/month/year (circle one)

5. What was the last level of school you completed? _____

6. Marital Status:
   ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never Married ☐ Separated

7. Children: _____# Boys _____# Girls

8. Employment Status: _____ Type of Work: _____

9. Do you have a history of drug use? ☐ Yes ☐ No

10. Do you have a history of alcohol abuse? ☐ Yes ☐ No

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
DRESSING & GROOMING				
Are you able to:				
Dress yourself, including shoelaces and buttons?	☐	☐	☐	☐
Shampoo your hair?	☐	☐	☐	☐
ARISING				
Are you able to:				
Stand up from a straight chair?	☐	☐	☐	☐
Get in and out of bed?	☐	☐	☐	☐
EATING				
Are you able to:				
Cut your own meat?	☐	☐	☐	☐
Lift a full cup or glass to your mouth?	☐	☐	☐	☐
Open a new milk carton?	☐	☐	☐	☐
WALKING				
Are you able to:				
Walk outdoors on flat ground?	☐	☐	☐	☐
Climb up five steps?	☐	☐	☐	☐

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

☐ Devices used for Dressing (button hook, zipper pull, etc.)
☐ Built up or special utensils
☐ Crutches
☐ Cane
☐ Wheelchair
☐ Special or built up chair
☐ Walker

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

☐ Dressing and grooming ☐ Arising ☐ Eating ☐ Walking

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
HYGIENE				
Are you able to:				
Wash and dry your body?	☐	☐	☐	☐
Take a tub bath?	☐	☐	☐	☐
Get on and off the toilet?	☐	☐	☐	☐
REACH				
Are you able to:				
Reach and get down a 5 pound object (such as a bag of sugar) from above your head?	☐	☐	☐	☐
Bend down to pick up clothing from the floor?	☐	☐	☐	☐
GRIP				
Are you able to:				
Open car doors?	☐	☐	☐	☐
Open previously opened jars?	☐	☐	☐	☐
Turn faucets on and off?	☐	☐	☐	☐
ACTIVITIES				
Are you able to:				
Run errands and shop?	☐	☐	☐	☐
Get in and out of a car?	☐	☐	☐	☐
Do chores such as vacuuming or yard work?	☐	☐	☐	☐

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

☐ Raised toilet seat
☐ Bathtub bar
☐ Long-handled appliances for reach
☐ Bathtub seat
☐ Long-handled appliances in bathroom
☐ Jar opener (for jars previously opened)

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

☐ Hygiene
☐ Reach
☐ Gripping and opening things
☐ Errands and chores

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.

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.
