**Informed Consent for use of Controlled Substances and Other Medication for**

**Treatment of Chronic Pain**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand and agree to follow the policy of Integrated Pain Solutions regarding the use of controlled and non-controlled substances/medication for management of chronic pain as set forth below. I agree and understand that Integrated Pain Solutions is under no obligation to prescribe these medications for me. I understand that there are other treatment options available and that the risk, benefits and alternatives have been discussed. I understand that I am being prescribed controlled substances for my chronic pain syndrome due to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that these medications have potential risk, the most significant being:

1. Physical dependence, which means that stopping the opioid medication suddenly could lead to withdrawal symptoms such as abdominal cramping, diarrhea, anxiety, inability to sleep, seizures and death.

2. Psychological dependence or addiction, which means that my behavior may become focused on obtaining additional opioid medication.

3. Tolerance, which means that after taking the medication for some time, if an acute injury is sustained, it may require higher doses of medication to treat my pain.

4. Over dosage of the opioid medication leading to respiratory difficulty and possibly death.

5. Mental changes, these drugs may result in drowsiness, sedation, dizziness, confusion and may affect your coordination or ability to think. This may make it unsafe for you to drive a vehicle, operate hazardous equipment, handle firearms or other weapons and perform other dangerous activities

6. Other side effects may include but are not limited to: constipation, nausea, vomiting, unsteadiness, decreased appetite, problems urinating, sexual difficulty and depression.

I agree to read the entire package insert of any medication prescribed to me and address any additional questions to the pharmacist or office staff regarding my medication.

I understand that I will receive opioid medication only from Integrated Pain Solutions and not from other sources. I understand that failure to notify the office in advance, of any anticipated acute pain need (additional surgery or dental work) that may require a change in my opioid dosage or short-acting medication from another surgeon.

I understand that if my physician determines that there are no demonstrable benefits in improved daily function from the opioid medication of that there are significant side effects or addictive behavior, I agree to gradually taper my medication as prescribed. If a substance abuse problem is suspected, I understand that I will be taken off the medications and referred to evaluation and management of this problem. I also understand that if I use illegal substances, of any kind, that my opioid medication will be withdrawn and I will be referred to a drug rehabilitation center and the authorities may be notified of illegal drug use. \_\_\_\_\_ (initials)

**Risk of other Controlled and Non-Controlled medication for Chronic Pain**

I understand that these medications have potential risk, the most significant being:

1. Physical dependence, which means that stopping the medication suddenly may produce withdrawal symptoms as outlined in the package insert received with your medication.

2. Psychological dependence or addiction, which means that my behavior may become focused on obtaining additional medication.

3. Overdose of the medication leading to sedation, confusion and other side effects as outlined in the package insert.

4. Mental changes, which may include but are not limited to drowsiness, sedation, confusion, forgetfulness, difficulty concentrating and other minor side effects as outlined in the package insert.

5, Other side effects, which may include but are not limited to stomach upset or possible ulcers, adverse effects on the heart, kidneys, liver, skin, glandular system, sexual function and other side effects as outlined in the package insert of these medications.

I also understand that State Law provides that it is unlawful for any person to knowingly acquire, obtain possession of, or to attempt to acquire or obtain possession of controlled substances by misrepresentation, fraud, forgery, deception or subterfuge. This also includes obtaining medication from more than one practitioner or consulting two or more practitioners solely to obtain additional controlled drugs or prescriptions for controlled drugs.

I have read this document, understand it and have had all my questions regarding risk complications and alternatives answered satisfactorily and I give my informed consent to use the medication prescribed.

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

I certify that I have reviewed this consent agreement with the above-signed individual.

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

I certify that the above-signed patient has knowingly and willing signed this consent.

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_