OPIOID PAIN MEDICATION AGREEMENT (3 Parts)

Patient (Part 1): Opioid pain medication is being prescribed for me as one part of my treatment to help better control my long standing pain and to help me reach the goals I have set to feel better (see Goals and Benefits on reverse side). In order to make this medication safe and follow national and state laws, I, ____________________________, understand that:

• This medication may not take away all my pain, and long-term benefit has not been proven.
• I should follow the directions exactly as given to me by my provider. Taking more than prescribed may hurt me.
• There are side effects of this medication described to me by my provider. All my questions about this medication have been answered. (see What a Patient Needs to Know About Opioid Medication on reverse side)
• I will call my provider’s office if I am having side effects after starting this medication.
• This medication may make me sleepy, increase my risk of falling, and make driving or operating machinery dangerous.
• Taking alcohol or street drugs along with this medication is dangerous.
• Taking this medication with other prescription drugs can also be dangerous. I will alert ALL my providers about my current medications, including over-the-counter (OTC) medicine, supplements, and herbs.
• My body may get used to the medication and it may not work as well. Also, if I stop it too quickly I could get sick.
• Some people become addicted to these medications. If I think this is happening to me I will speak to my provider.

Patient (Part 2): I, __ ______________________________________, agree:

• To get pain medication only from the provider signed below, or his/her medical team.
• To notify my provider immediately if I obtain any pain medication from an emergency room.
• To get pain medication only during regular office hours and not to call after office hours for pain medication.
• To fill my medication at only one (1) in-state pharmacy. The contact information is:

  Pharmacy name: _____________________________ Phone: ____________________________

• To give urine samples and to bring my pills to be counted whenever asked of me.
• Not to use illegal drugs or non-prescribed prescription drugs along with this medication.
• Not to sell or give away my medication.
• To keep my medication safe. If it is lost or stolen, I understand it may not be replaced.
• To allow my provider to exchange information with people who might need to know about my medication use if he/she thinks it is necessary for my health and safety.
• To keep all of my health care appointments recommended to me to treat my pain.
• That my medication can be stopped at any time, after a discussion with my health care provider.

Health Care Provider (Part 3): I, __ ______________________________________, agree:

• To explain your pain condition and how opioids are expected to help.
• To explain the risks, side effects and alternatives to opioid treatment.
• To monitor your pain level at each visit to help assure good pain control and help meet your goals (see Goals and Benefits).
• To continue to change the plan as needed to get improved activity and better control of pain.
• To include a pain specialist, and/or other health care specialists (such as Behavioral Health, Physical Therapy, Massage Therapy, Acupuncture) in your care, as needed to reach your goals (see Goals and Benefits).
• To make clinical decisions I believe are in your best interest, including discontinuing opioids.
• To keep you safe, to the best of my abilities, including running SCRIPTS DHEC reports while you are taking opioid medications. I will provide help if you become addicted.

Consent to treatment and Agreement to responsibilities outlined above: My health care provider and I have reviewed this document, including What a Patient Needs to Know About Opioid Medication (on reverse side); and I have been given the opportunity to have any questions answered. I understand the possible benefits and risks of opioid medications. My health care provider and I each accept our respective responsibilities described above.

______________ __________ ______________________________ __________
Patient signature Date Health Care Provider signature Date

______________ __________ ______________________________ __________
Patient name printed Date Health Care Provider name printed Date

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What a Patient Needs to Know About Opioid Medication

Goals and Benefits

- If opioid medication is prescribed, it is just one part of a total pain management plan. Expected benefits and goals of opioid medication to treat pain include:
  - Improved pain
  - Improved ability to engage in work, social, recreational and/or physical activities
  - Improved quality of life
  - Improvement of more specific goals I discussed with my provider

Side Effects, Effects of Medication Combinations and Addiction Risk

- I need to tell my provider if I notice any problems. Opioid pain medications often have side effects, which may include but are not limited to:
  - Itching
  - Rash
  - Nausea
  - Constipation, sometimes severe
  - Trouble urinating or passing stool/poop
  - Drowsiness
  - Slow or depressed breathing (especially if obese)
  - Problems thinking clearly
  - Mood changes
  - Depression getting worse
  - Increased risk of bone fractures or brittle bones
  - May worsen sleep apnea (periods of not breathing while sleeping)
  - Sexual difficulties, such as lack of menstrual periods in women and low male hormone in men
  - Rash (especially if obese)
  - Problems thinking clearly
  - Mood changes
  - Depression getting worse
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  - Nausea
  - Problems thinking clearly
  - Mood changes
  - Depression getting worse
  - Increased risk of bone fractures or brittle bones
  - May worsen sleep apnea (periods of not breathing while sleeping)
  - Sexual difficulties, such as lack of menstrual periods in women and low male hormone in men

- I need to tell my provider if I am a woman who is pregnant or plans to become pregnant. Risks to unborn children in women include:
  - Physical dependence at birth
  - Possible changes in pain perception
  - Possible increased risk for development of addiction

- I need to check with my provider or pharmacist before taking any over-the-counter (OTC) medications that contain acetaminophen (i.e., APAP, Tylenol®). ALWAYS read labels to check for added acetaminophen. Acetaminophen can be ‘hidden’ in medicine such as cough/cold or menstrual cramp medicines. Some opioid pain medications (such as Vicodin®, Lortab®, Norco®, Percocet®) also contain acetaminophen. Too much acetaminophen may cause liver damage.

- If I decide to stop my medication, I will contact my provider. If I must stop this medication for any reason, I need to stop it slowly to help me avoid feeling sick from physical withdrawal symptoms. Withdrawal symptoms include:
  - Anxiety
  - Irritability
  - Aching, Pain
  - Sweating
  - Abdominal/Stomach cramping
  - Diarrhea

- I may develop an increased sensitivity to pain.

- I could become addicted to this medication. If anyone in my family or I have ever had drug or alcohol problems I have a higher chance of getting addicted to this medication. Addiction is associated with drug craving, loss of control, and poor response to treatment.

Other Risks to Others and Myself

- If I do not use this medication exactly as prescribed, I risk hurting others and myself (such as a car accident).

- If I do not secure or dispose of this medication properly, I risk hurting others, especially children, who find it and accidentally take it. There is also a possible risk to my household and me to theft, deceit, assault or abuse by persons seeking to obtain my medications for purposes of misuse.