CANYON RIDGE
Pain Relief Specialists

Consent for Chronic Opioid Therapy

Dr. Raul Weston is prescribing opioid medicine, sometimes called narcotic analgesics, to me for a diagnosis of _____.

This decision was made because my condition is serious or other treatments have not helped my pain. I am aware the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness, drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief. I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed included:
_____
_____

I will tell my doctor about all other medicines and treatments that I am receiving. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: using heaving equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself. I am aware that other medicines such as nalbuphine (Nabain), pentazocine (Talwin), buprenorphine (Buprenex) and butorphanol (Stadol), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree to not take any of these medicines and to tell my doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines list above.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge. I understand that physical dependence is a normal, expected result of using these medications for a long time.

I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medication use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means that I may have any of all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and flu-like symptoms. I am aware that opioid withdrawal is uncomfortable but not life threatening. I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief.

I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain, however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may

cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

(**Males Only**) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

(**Females Only**) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

I will take the opioid medicine only as prescribed. Any changes must first be discussed and agreed upon with Dr. Raul Weston.

Medications will not be replaced if they are lost, get wet, are destroyed, left on airplane, etc. If my medication has been stolen and I complete a police report regarding the theft, an exception may be made. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might have access to them.

I agree that only Dr. Raul Weston will prescribe my opioid medication. I will not obtain or use opioids or other controlled substances from a source other than Canyon Ridge Pain and Spine. If it is brought to the attention of the clinic that other providers are prescribing medications for me, Canyon Ridge Pain and Spine reserves the right to discontinue prescribing medication and/or discharge me from the clinic.

This medication will be strictly monitored and all of my medications should be filled at the same pharmacy. Should the need arise to change pharmacies our office must be informed.

I agree to tell my physician my complete and honest personal drug/medication usage and history.

Routine and random drug screens may be a part of my treatment plan. I agree to have them done on the day the physician requests it.

It is understood that failure to adhere to this agreement may result in cessation of therapy with controlled substance prescribing (no opioid prescriptions will be written) by Dr. Raul Weston.

I have read the Opioid Contract and understand all of this agreement. By signing this agreement I affirm that I have read, understand and accept all of the terms of this agreement.

Patient signature: _____ Date: _____

Clinic Witness: _____ Date: _____