

Stacy Medical Center / Alameda Industrial Medical Group  
Pain Management - Opioid Contract: Page 1 of 2

You have agreed to receive opioid (narcotic) medications for the treatment of acute / sub-acute / chronic pain. These medications are being prescribed to decrease your pain and/or increase your ability to function. Opioid medications are just a part of the medical care which may be needed to accomplish this. Other treatments including non-opioid medications, exercise and physical therapy, psychological counseling or other therapies or treatments may also be prescribed.

Please read this contract carefully. If you do not understand any of the information contained below, or require additional clarification on the policies of this office regarding the prescribing of opioid medications, please ask. You will be required to sign this contract before receiving any opioid medications.

I, \_\_\_\_\_, understand that adhering to the following is important in continuing to receive opioid medications prescribed by: S. Florman, MD / R. Ojima, MD / R. Tanzer, MD / S. Blaser PA / C. Davis PA

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1. I understand that I will
  - a. Take medications **only** as they are prescribed by this physician. This includes the prescribed dose and frequency.
  - b. Not increase or change medications without the approval of this physician.
  - c. Not request or attempt to get opioid or other medications from any other physician unless specifically directed by this physician.
  - d. Tell this physician of all the medications that I am taking.
  - e. Only obtain my medications from one pharmacy. If I need to change or obtain medications from a different pharmacy, I will tell this physician immediately.
  - f. Safeguard and protect my prescriptions and medications. I understand that these **will not** be replaced if they are lost, left behind, or destroyed. If my medication is stolen I will complete a police report understanding that only one stolen prescription **may** be replaced in a year.
  - g. Agree to participate in psychiatric or psychological treatment or counseling, if needed.
  - h. Adhere to the following if I have an addiction problem.
    - i. I will not use illegal or street drugs, alcohol, or other medications that were obtained illegally or that were intended for use by someone other than me.
    - ii. I will follow the advice of this physician and enter an addiction program such as:
      1. 12-step program and secure a sponsor.
      2. Individual counseling.
      3. Inpatient or outpatient treatment.
      4. Other: \_\_\_\_\_
2. I understand that in the event of an emergency, this physician should be contacted and the problem will be discussed with the emergency room or other treating physician. No more than three days of medications may be prescribed by the emergency room or other physician without this doctor's approval.
3. I understand that I will consent to random drug screening. A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.
4. I understand that this physician may stop prescribing opioid medications or change the treatment plan if:
  - a. I trade, sell or misuse the medication.
  - b. The clinic finds that I have broken any part of this agreement.
  - c. I do not go for a blood or urine test when asked.
  - d. My blood or urine test shows the presence of medications the staff is not aware of, the presence of illegal drugs, or does not show medications that I am receiving a prescription for.
  - e. I get opioid medications from sources other than this physician.
  - f. Any member of the professional staff of this clinic feels it is in my best interests that opioid medications are stopped.
  - g. I display any aggressive behavior toward my physician or any of the clinic staff.
  - h. I consistently miss appointments.

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Patient Signature

Date

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Physician Signature

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**SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF OPIOID MEDICATIONS:**

There are potential adverse effects of opioid medications that are potentially dangerous. These include delayed reaction time, impaired judgment, drowsiness, and rarely, physical addiction. Any of these may impair your ability to drive or operate heavy machinery. These adverse effects tend to diminish over time.

**ADVERSE EFFECTS OF OPIOID MEDICATIONS:**

*These adverse effects may be made worse when mixing opioid medications with other medications, including alcohol!*

- Feelings of anxiety
- Confusion
- Dizziness or drowsiness
- Impaired judgment
- Slowed or difficult breathing
- Constipation
- Nausea
- Vomiting
- Slow heart rate
- Excess sweating
- Difficulty urinating
- Physical or psychological dependence

**RISKS**

- Physical dependence. This means that abruptly stopping the medication may lead to withdrawal symptoms which may include:
  - Runny nose
  - Diarrhea
  - Sweating
  - Rapid heart rate
  - Difficulty sleeping for several days
  - Abdominal cramps
  - Shakes and chills
  - Nervousness

**RECOMMENDATIONS TO MANAGE YOUR MEDICATIONS:**

- Keep a diary of the pain medications you are taking, the dose, the time of day you are taking them, their effectiveness, and any adverse effects you may be having.
- Using a "pill" reminder box which is available at the pharmacy may make it easier for you to remember when to take your medications.
- Store your medications in a safe place, away from excess light and humidity. This helps to ensure that the medication retains its effectiveness. This also helps to safeguard your medicines and minimize the chance that that they will be stolen.

**I have read the *Pain Management Contract* and without question understand all of the information and responsibilities contained in this contract. By signing this contract I affirm that I have read, understand and accept all of the terms of this contract.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinic Witness: \_\_\_\_\_ Date: \_\_\_\_\_