CPHCS
Chronic Pain Provider-Patient Agreement/Informed Consent for Opioid Pain Medication

This is an agreement between _____(the patient) and _____ (the provider) concerning the use of opioid medications for the treatment of a chronic pain problem.

1. I understand that opioid medications are used as one part of a chronic pain treatment program and that they have risks and side effects involved with taking them. I have been informed of these risks and discussed them with my provider.

2. I understand that the medication will probably not eliminate my pain, but will be used to attempt to reduce my pain enough that I may become more active. Most patients see about a 30% decrease in their pain.

3. Chronic pain is a difficult problem that requires a team approach. I must keep all the appointments (Physical Therapy, specialist clinicians, pain groups and counselors) that my pain management provider recommends for my treatment, or my opioid medication may be stopped.

4. I understand that treatment with opioid pain medications is being started on a trial basis. I will get more medications depending on the benefits I show and also the problems that develop.

5. In particular, I understand that opioid medications can cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable, but not a life-threatening condition.

6. Overdose on this medication may cause death by stopping my breathing; this can be possibly be reversed by emergency medical personnel if they know I have taken opioid medications.

7. If the medication causes drowsiness, sedation, or dizziness, I understand that if my job requires, I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.

8. I understand it is my responsibility to inform the provider of any and all side effects I have from this medication.

9. I agree to take this medication as prescribed and not to self diagnose, or demand the provider change the amount or frequency of the medication without a medical reason. Running out early, needing early refills, or increasing doses or more frequent dosing may be signs of misuse of the medication and may be reasons for the provider to discontinue prescribing to me.

10. Seeking opioid medication from other providers may be a reason for my provider to discontinue the opioids.

11. I agree not to sell, lend, or in any way give my medication to any other person. If I am found to be cheeking my medicine it will be stopped. If I am suspected of hoarding my medication, custody may be notified and a search of my housing may result.

12. I agree not to drink alcohol or take other non-prescribed mood-altering drugs while I am taking opioid medication.

13. My provider may request urine or blood drug screens from time to time to monitor my use of pain medications, and to detect improper use of medications not prescribed. I agree to submit to these tests and understand if I refuse the testing, my provider will need to stop my opioid medication. In the event that these tests indicate that my use of opioids or other medications presents a health risk to myself or to others, my provider may taper and stop the opioid medication. If my test results indicate a danger to myself or others, I authorize my medical provider to notify Custody. _____ (pt. initial).

14. I understand that there is a risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued. I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the doctor may discontinue this form of treatment.

Patient Signature: _____
Provider Signature: _____
Date: _____

CDCR Stamp:

Patient Name:

CDCR #

DOB:

CDCR 7474 (12/09)

ATTACHMENT F (ENGLISH)