

**Genesis Medical Clinic**  
11531 N. 56<sup>TH</sup> ST  
TEMPLE TERRACE, FL.33617  
813-549-7465

## A consent/Agreement form,

Dr. \_\_\_\_\_ 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 that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or 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 that combining the prescribed medication with alcohol, street or illegal drugs, taking more medication than that prescribed will produce the above effect and may cause cardiac arrest, coma or possibly death.

I am aware that consuming alcohol with tylenol or any acetaminophen containing medication greater than 2 gram per day will increase my chance of liver toxicity and possibly death.

\_\_\_ 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:-----

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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 heavy 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 certain other medicines such as nalbuphine (Nubain™), 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 not to take any of these medicines or alcohol, street or illegal drugs and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed 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 medicines 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 medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. 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 have read this form or have had it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines.

Patient Signature and Date \_\_\_\_\_

Patient's Name \_\_\_\_\_

Witness Signature \_\_\_\_\_

Witness Name \_\_\_\_\_

# NARCOTIC AGREEMENT

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The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged.

For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment or toxicity leading to death.)
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

Pharmacy Name: \_\_\_\_\_ phone: \_\_\_\_\_  
Fax# \_\_\_\_\_, Address \_\_\_\_\_  
\_\_\_\_\_

3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take. You are to inform our office within 48 hrs of any visit to the emergency room or admission to the hospital.

4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists, primary care physician, designated family member, significant other, caregiver and other professionals who provide your health care for purposes of maintaining accountability.

5. You must not share, sell, or otherwise permit others to have access to these medications or buy these medications through the internet.
6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop. You agree to go to a detox center should abrupt cessation occur.
7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.
8. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. 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 see or otherwise have access to them.
9. Original containers of medications should be brought in to each office visit.
10. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
11. Medications will not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, you must wait for your next office visit.
12. You must not use these medications in a manner inconsistent with its labeling. You must not snort, shoot, inject any of these medications into your body.
13. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.
14. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

15. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.

16. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

17. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.

18. The risks and potential benefits of these therapies are explained elsewhere [and you acknowledge that you have received such explanation].

19. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

20. You agree to visit other specialists or other health care providers when referred by your doctor.

Physicians Name: \_\_\_\_\_

Physician Signature : \_\_\_\_\_

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

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

Date: \_\_\_\_\_

Witness Name: \_\_\_\_\_

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

Date: \_\_\_\_\_