Rheumatology
SOLUTIONS

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Consent for Controlled Substances Therapy for Chronic Pain

Dr. _____ is prescribing an opioid (narcotic) or other controlled substance to me because my condition is serious or other treatments have not helped control my pain.
NAME:_____ DOB _____
DIAGNOSIS:_____
MEDICATION(S) PRESCRIBED:_____

I am aware of the following risks associated with the chronic opioid or other controlled substances therapy:

1. Symptoms such as sleepiness, constipation, nausea, itching, vomiting, dizziness, allergic reactions, slowed breathing rate, slowed reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and incomplete pain control.

2. Slowed reflexes and reaction time may make it dangerous for me to drive a vehicle, work on unprotected heights, use or operate heavy equipment or machinery, or when I am responsible for another individual unable to care for him or her self.

3. Medication reactions: Nalbuphine (Nubain™), pentazocine (Talwin™), buprenorphine (Buprenex™) and Butorphanol (Stadol™) may reverse the action of my pain medication. This can cause symptoms like a bad flu, called a withdrawal syndrome. My other doctors need to know what medications I am taking to avoid prescribing these medications.

4. Addiction: The chance of becoming addicted is low, but has been reported in medical journals. It is more common in persons with a family or prior personal history of addiction. A person who is addicted will take this medication even while knowing it is causing them harm, may have cravings for the drug, feel the need to take the drug, and experience a decreased quality of life.

5. Physical Dependence: This is a normal, expected result of using these medications for a long time. It is not the same as addiction. If the dose is markedly decreased, stopped abruptly, or reversed by other drugs, a withdrawal syndrome may occur. Withdrawal symptoms include: runny nose, yawning, large pupils, goose bumps, abdominal pain, cramping, diarrhea, irritability, body aches and a flu-like feeling. Withdrawal is uncomfortable but not life threatening.

6. Tolerance to analgesia: I may require more medicine to get the same amount of pain relief over time. Increasing doses may not always help and may lead to unacceptable side effects. Tolerance may require choosing another form of treatment.

7. (Males only) Chronic opioid use has been associated with low testosterone levels. This may affect mood, stamina, sexual desire and physical and sexual performance. I understand my doctor may check my blood to determine if my testosterone is normal.

8. (Females only) If I plan to become pregnant or believe that I have become pregnant while taking this medication, I will immediately call my obstetric doctor and Dr. _____'s office to inform them. Should I carry a baby to delivery while taking these medications, the baby will be physically dependent. I am aware that use of opioids is not generally associated with a risk of birth defects, but they can occur, and I may need to taper off and discontinue them during or before becoming pregnant.

I am aware of the possible risks and benefits of other types of treatments that do not involve the use of controlled substances. Other treatments discussed include *physical therapy, acupuncture, topical analgesics, acetaminophen, non-steroidal anti-inflammatory drugs, Ultram(tramadol) and other modalities.*

I have read this form, or had it read to me. I understand all of it. I have had a chance to have all 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 medicines or other controlled substances.

Patient Signature:_____Date:_____

Patient name:_____

Witness Signature:_____Date:_____

Witness name:_____

A consent form adapted courtesy of the **American Academy of Pain Management** *and from the* Management of Opioid Therapy for Chronic Pain Working Group, VA/DoD Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain, March 2003.