IDEAL PAIN MANAGEMENT

Consent for Chronic Opioid (Narcotic) Therapy

Dr. Gariwala/Physician Assistant is prescribing opioid medicine (narcotic analgesics) to me for my pain on regular basis. This decision was made because my condition is very painful, affects my function and other treatments have not helped my pain.

I am aware that if I use other sedative medications (i.e. Xanax, Valium, Klonopin, etc.) or drink alcohol with these medications then it may cause severe drowsiness, sedation: it may depress my breathing and may even cause death. I will not drink alcohol and I will not use sedative medicine prescribed by another doctor without checking with IPM physician/PA.

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, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, addition 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.

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.

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 understand that physical dependence is an expected result of using these medicines for a longtime.

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.

Long-term effects of these medications are not very well understood; I understand that I may have long-term side effects of these medications including adrenal insufficiency.

(Males) 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.

(Females) I will take precautions so that I do not become pregnant. If I do, then I will call my obstetrician and this office to inform. 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 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: _____Date:_____

Patient's Name: _____

Ideal pain:_____