Andrea Henley- Seymour, M.D.
Seymour Spine & Rehabilitation, LLC.
4399 N Nob Hill Road
Sunrise, Florida, 33351
Main: 954 315-7978 Fax: 954 746-1438

INFORMED OPIOID TREATMENT CONSENT FOR CHRONIC PAIN

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician/health care provider comply with all state and federal regulations concerning the prescribing of controlled substances. The long- term use of opioid therapy is somewhat controversial because of uncertainty regarding the extent to which this treatment actually improves the quality of life of those receiving it.

The risks, benefits, and alternatives have been discussed with me by my prescribing physician, therefore I have agreed to use opioids (morphine-like drugs) as part of my pain management treatment regimen. I understand that these drugs have a high potential for misuse and are therefore closely controlled by the local, state, and federal government. I agree to the following conditions:

Patient's
Initials

_____A trial of opioid therapy can be considered for moderate to severe pain with a goal of reducing pain **and** increasing function. If it appears to the physician/health care provider that there is no improvement in my daily function or quality of life from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed by the physician.

_____There are **side effects with opioid therapy**, include but are not limited to; skin rash, nausea, constipation, urinary retention, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation/drowsiness, or the possibility of impaired cognitive (mental thinking) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing).
It is my responsibility to notify my physician/health care provider for any side effects that continue or are severe (i.e., sedation, confusion). I am also responsible for notifying my pain physician immediately if I need to visit another physician or need to visit an emergency room due to pain, or if I become pregnant. Children born to mothers who have been prescribed opioids are likely to be born with physical dependence on the opioid.
I should inform my physician of all medications I am taking sedatives like Valium, Ativan, Soma, or Xanax; analgesics like Fiorinal or Tramadol; antihistamines like Benadryl; alcohol containing- meds or herbal remedies. Prescribed and over- the- counter medications such as these can interact with opioids and produce serious side effects.

_____ I understand that decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal. **Withdrawal symptoms** can include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, abdominal cramps, and diarrhea. These symptoms can occur 24-48 hours after the last dose and can last up to 3 weeks. I understand that increasing my dose without the close supervision of my physician could lead to drug overdose causing severe sedation and respiratory depression and death.

_____ Any evidence of drug hoarding, getting any opioid medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship. **I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician/health care provider.** I understand that the opioid medication is strictly for my own use. The opioid should **Never** be given or sold to others because it may endanger that person's health and is **AGAINST THE LAW.**

_____You should not use any illicit substances, such as cocaine, marijuana, etc. while taking these medications. You should not drink alcohol while being prescribed opioid medications. This may result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship.

_____I am responsible for my opioid prescriptions. I understand that:

a. Refill prescriptions can be written for a maximum of one month supply and will **ONLY** be filled at the pharmacy listed below. I understand that opioid prescriptions **will not** be mailed. If I am unable to obtain my prescriptions monthly, I will be responsible for finding a local physician who can take over the writing of my prescriptions with consultations from Dr. Henley-Seymour.
If I have to change pharmacies to fill the prescription given by Dr. Henley-Seymour, then I will contact the office immediately to change the information given below.
Pharmacy: _____ Phone number: _____

b. **It is my responsibility to schedule appointments for the next opioid refill before I leave the clinic or within 3 days of the last clinic visit.**
I will be seen on a regular basis and given prescriptions for enough medication to last from appointment to the next appointment, and sometimes two to three days extra **if** the prescription ends on a weekend or holiday. This extra medication is **not** to be used without the explicit permission of the prescribing physician unless an emergency requires your appointment to be deferred one or two days.

c. I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. Then, report the stolen medication to my physician. If my medications are lost, misplaced, or stolen my physician may choose not to replace the medications or to taper and discontinue the medications.

d. Prescriptions for pain medicine or any other prescriptions will be done only during an office visit or during regular office hours**. No refills of any medications will be done after business hours, on weekends, or holidays, no exceptions.**

e. If an appointment for a prescription refill is *missed*, another appointment will be made as soon as possible. *Immediate* or *emergency* appointments will not be granted. No "walk-in" appointments for opioid refills will be granted.

_____ While physical dependence, and sometimes tolerance, is to be expected after long-term use of opioids, **signs of addiction, abuse, or misuse shall prompt the need for substance dependence treatment as well as weaning and detoxification from the opioids.**

_____There is a potential risk of an addictive disorder developing or of relapsing occurring in a person with a prior addictive disorder. If I have a history of alcohol or drug misuse/addiction, I must notify the physician of such history since the treatment with opioids for pain **may** increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery **is a necessity.**

_____I agree and understand that my physician reserves the right to perform random or unannounced urine/saliva drug testing. If requested to provide a urine/saliva sample, I agree to cooperate. If I decide not to provide a urine/saliva sample, I understand that my doctor may change my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the doctor/patient relationship. The presence of a non-prescribed drug (s) or illicit drug (s) in the urine can be grounds for termination of the doctor/patient relationship. Urine/saliva drug testing is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.

_____I understand and agree that my physician is at complete liberty to discuss all diagnostic and treatment detains with pharmacists at the dispensing pharmacy for purposes of maintaining accountability.

_____I understand that non-compliance with the above conditions may result in a re-evaluation of my treatment plan and discontinuation of opioid therapy. I may be gradually taken off these medications, or even discharged from the clinic.

_____I have been given a copy of this Informed Opioid Treatment Consent, signed by me or my legal representative and the prescribing physician.

I _____ have read the above information or it has been read to me and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy & acknowledge receipt of this document.

Patient or Legal Representative's Signature _____

Print Patient or Legal Representative's Name_____

Witness's Signature_____ Date_____

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed plan for a trial of opioid medications, to the patient/legal representative. I have answered all questions fully and I believe that the Patient/ Legal Representative fully understands what I have explained.

Physician Signature/ Date_____