

Long Term Opioid Therapy Consent and Medication Agreement

This Agreement sets out the rules for taking prescribed pain medicines and the rules for prescription refills.

This form must be completed and submitted via fax. If you have any questions about this form, please call:

Health Care Services

FAX: (866) 572-4384

PHONE: 532-4006 (Oahu)

1-800-458-4600 extension 300 (toll free from the Neighbor Islands)

1. Name of the treatment: Long-Term Opioid Therapy for Treatment of Pain
2. Practitioner obtaining consent: _____
3. Supervising practitioner (if applicable): _____

A. INFORMATION ABOUT THE TREATMENT

4. Reason for long-term opioid therapy (diagnosis, condition, or indication): _____
5. Location of pain: _____
6. Goal(s) of long-term opioid therapy (check all that apply):

<input type="checkbox"/> Pain Score	<input type="checkbox"/> Start a light exercise program	<input type="checkbox"/> Return to work	<input type="checkbox"/> Other
<input type="checkbox"/> Functional abilities (go back to work, climb stairs, walk short distance, sleep through the night, do daily household chores)			

7. Name of current or initial opioid medication(s): _____
8. Brief description of the treatment:

Opioids are very strong medicines that may be used to treat pain. You may already be taking opioids. Or your provider may try to give you opioids to find out if they will help you. They may try them for a short time or continue them for the rest of your life. Your provider will learn more about your risks and side effects when you are trying the opioids. If the risks and side effects outweigh the benefits, your provider will stop the prescription. If your provider continues your opioid prescription, the goals of your treatment may change over time. The names and doses of your opioids may also change. You will not need to sign another consent form for these changes. You may be asked to sign another consent form if you seek opioid pain care from another provider.

Your provider will monitor your prescription. This may include checking how often you refill and renew your prescription, counting pills, asking you about your symptoms, and testing your urine, saliva, and blood. If you do not take opioids responsibly, your provider may change or stop your prescription. For example, if you do not let your provider monitor how you are responding to the opioids or tell them if you are taking other drugs that may affect the safety or effectiveness of your opioid treatment, your provider may stop or change your prescription. For your safety, your provider and pharmacist will monitor when you renew and refill your opioids. Hawaii has a prescription monitoring program that tracks unsafe patterns of prescription drug use. Your provider and this program may obtain and share information about you without your specific consent.

9. Potential benefits of the treatment:
Opioids, when added to other treatments as part of your pain care plan, may reduce your pain enough for you to feel better and do more. It is unlikely that opioids will eliminate your pain completely. It is possible that you may not receive any benefits from opioid therapy.
10. Known risks and side effects of the treatment.

Possible opioid side effects include:

Sleepiness or Slow thinking	Itching, Sweating
Mental confusion, bad dreams, or hallucinations	Nausea or vomiting
Decreased sex hormones	Depression

Irregular or no menstrual periods	Dry mouth that causes tooth decay
Constipation or in rare cases, intestinal blockage	Allergies

Other risks of opioid therapy:

Sleep apnea (abnormal breathing pauses during sleep)	Worsening of pain
Impaired driving or impaired ability to safely operate machinery	Death
Withdrawal symptoms if you suddenly stop taking opioids, lower the dose of your opioids too quickly, or take a drug that reverses the effects of your opioids. Withdrawal symptoms are caused by a physical dependence that is a normal result of long-term opioid therapy. Some common withdrawal symptoms are: runny nose, chills, body aches, diarrhea, sweating, nervousness, nausea, vomiting, mental distress, and trouble sleeping.	
Increased tolerance. You may need a higher dose of opioid to get the same pain relief, resulting in an increase in the likelihood of the other side effects and risks.	
Addiction (craving for a substance that gets out of control). Some patients become addicted to opioids even when they take opioids as prescribed.	
Drug interactions (problems when drugs are taken together). Taking small amounts of alcohol, some over-the counter medications, some herbal remedies, and other prescription medications can increase the chance of opioid side effects.	
Risks in pregnancy: Continued use of opioids during pregnancy can cause your baby to have withdrawal symptoms after birth and require your baby to stay in the hospital longer after birth. Stopping opioids suddenly if you are pregnant and physically dependent on opioids can lead to complications during pregnancy. Studies have not shown a clear risk for birth defects with opioid use in pregnancy. If there is an increased risk for birth defects in pregnancy with opioid use, it is likely small.	

11. Alternatives to the treatment: You have the option not to take opioids. Other treatments can be used as part of your pain care plan. Not all alternative therapies are appropriate for all patients. Ask your provider what alternative therapy is appropriate for you. Alternatives include:

Rehabilitation	Weight Loss
Stretching, Exercise	Relaxation or stress reduction training
Nerve Stimulation	Counseling & coaching
Self-care techniques	Specialist pain care
Injections	Surgery
Heat & cold therapy (heating pads, ice packs)	Meditation
Chiropractic	Physical Therapy
Mental health treatment	Massage
Support groups	Acupuncture
Attention to proper sleep	Non-opioid pain medicines (Non-steroidal anti-inflammatory drugs, antidepressants, anticonvulsants)
Pain classes	Occupational Therapy

12. Additional Comments:

B. SIGNATURES

1. **Practitioner** obtaining consent:

- All relevant aspects of the treatment and its alternatives (including no treatment) have been discussed with the patient in language that s/he could understand. This discussion included the nature, indications, benefits, risks, side effects, monitoring, and likelihood of success of each alternative that was considered.
- The patient demonstrated comprehension of the discussion and has been given the opportunity to ask questions.

Provider Signature: _____

Date: _____

2. **Patient Signature:**

- I understand that to receive long-term opioids I must agree to my opioid treatment plan by signing this consent form.
- Someone has explained the treatment, what it is for, and how it could help me.
- Someone has explained things that could go wrong, including serious side effects and death, particularly if I do not take my medicine as prescribed.
- Someone has told me about other treatments that might be done instead, and what would happen if I have no treatment.
- I understand the importance of:
 - Telling my provider about side effects.
 - Telling my provider about changes in my pain and daily function.
 - **Getting my opioid prescription from only my primary pain management provider and no one else.**
 - Not giving away (or selling) my opioids to other people.
 - Storing my opioids in a safe place away from children, family, friends, and pets.
 - Not drinking alcohol or taking illegal street drugs when I am on opioids.
 - For women, telling my provider if I think I might be pregnant, know I am pregnant, or am planning to become pregnant
- I plan to use my medications responsibly, and take them as prescribed.
 - I understand that if I do not take my medication as prescribed, my provider will talk to me about changing my opioid treatment plan.
 - This conversation may result in a change in or discontinuation of my pain medication prescription.
- I understand how to refill my opioid prescription or get a new prescription.
 - I understand that my prescribing provider may not be available on weekends, holidays, and after regular clinic hours and I will plan my medication needs accordingly.
- I understand that my provider might not give me early medication refills or replace doses that are lost or stolen.
- I understand that my provider may order urine drug tests.
 - I understand that the results of these tests or my refusal to be tested will cause my provider to talk to me about changing my opioid treatment plan.
 - This conversation may result in a change in or discontinuation of my pain medication prescription.
- I understand that I may have to stop opioids if my provider thinks that it is unsafe for me to continue.
- Someone has answered all my questions.
- Someone has given me information about how to contact my pain management provider if there is a problem and who to call in an emergency.
- I know I may refuse or change my mind about having treatment.
- I have been offered the opportunity to review and receive a copy of my consent form.
- I choose to have this treatment.

Patient's Signature: _____

Date: _____