AGREEMENT FOR TREATMENT OF CHRONIC PAIN WITH OPIOIDS (NARCOTIC PAINKILLERS)
Revised 3/6/2016

PATIENT NAME: _____

I am aware that the continued use of narcotic medications is being considered only after all other attempts at pain relief to allow for increased function have failed.

I am also aware of the potential risks involved with long term use of opioids include but are not limited to:

1. constipation
2. decreased appetite
3. confusion or other change in mental state or thinking abilities, impaired judgment, delay in response time--all of which may make activities such as driving or operating power equipment less safe. Therefore, I will not engage in any activities such as driving or operating heavy equipment if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reaction times might be slowed.
4. drowsiness or increased sleepiness.
5. slow breathing--overdose could lead to respiratory arrest and death.
6. for female patients who become pregnant there is the risk of your newborn being physically dependent on the drug at birth.
7. male patients may experience low levels of male hormone testosterone which may affect my mood, stamina, sexual desire and performance.

THE FOLLOWING CONDITIONS MUST BE MET PRIOR TO AND DURING CHRONIC OPIOID THERAPY:

1. Other reasonable forms of treatment have not been effective or have produced too many side effects.
2. I do not have problems with substance abuse or dependence, nor have I been involved in the sale, illegal possession or diversion of controlled substances.
3. I will obtain prescriptions for these medications only from Dr.

Greenberg, or from another physician only with Dr. Greenberg's permission.
4. I will take my medicines only as prescribed, and under no circumstances will I allow any other individuals to use my medications.
5. I will allow Dr. Greenberg to communicate with my referring physician, or any other physician or pharmacist regarding my use of controlled substances or any other medical, psychological or social conditions Dr. Greenberg deems relevant to my care.
6. I will comply with Dr. Greenberg's recommendations regarding discontinuing these medications should he feel it advisable.
7. if female, I certify that I am not pregnant, and will use appropriate measures to prevent pregnancy during the course of treatment with opioids.
8. I understand that NO allowance will be made for lost prescriptions or drugs. Prescriptions will not be refilled early under any circumstance.
9. I will keep all of my scheduled appointments.
10. I will remain on the prescribed dose of medication; I will not make any changes in the use of the medications without first discussing changes and obtaining permission from Dr. Greenberg or his staff.
11. I will see any other provider recommended by Dr. Greenberg, and comply with their therapeutic recommendations.
12. I understand that evidence of drug hoarding, acquisition from other physicians, uncontrolled dose escalation, or other misuse of the medications will result in the tapering and discontinuation of medication and potential dismissal from Dr. Greenberg's practice.
13. I understand that these medications may be sought by individuals with substance abuse problems, or may be dangerous to other persons not tolerant to their effects. Therefore I accept responsibility to insure the security of these medications
14. Use of these medications initially is on a trial basis, and continued use is contingent upon evidence of benefit. I understand that success of treatment will be measured by gains in social and physical function and activity level rather that solely on pain relief.
15. I understand that these medications can have serious even fatal side effects including but not limited to respiratory arrest (stop breathing) and death. Moreover I understand that mixing these medications with other sedating substances such as ALCOHOL, OTHER PRESCRIBED OR NON-PRESCRIBED DRUGS, SLEEP MEDICATIONS OR ANTI-ANXIETY MEDICATIONS SUCH AS VALIUM CAN LEAD TO FATAL OVERDOSE. I will NOT use any of the aforementioed substances or any other medications without informing

Dr. Greenberg or his Staff.
16. Current Nationally accepted evidence-based guidelines regarding the use of these medications identify proper dosing and monitoring criteria. This includes the use of URINE DRUG TESTING on a regular basis. I agree to this testing at the sole discretion of Dr. Greenberg

DEFINITION OF TERMS RELATED TO OPIOID THERAPY

Addiction—a chronic psychosocial disease state characterized by compulsive drug-seeking behaviors, despite harm caused by the use of the drugs
Dependence—a state of adaptation manifest by a withdrawal syndrome that can be produced by abrupt decreases in drug dose.
Tolerance—a state of adaptation in which an increase in dose is required to achieve the same physiologic or therapeutic effects

EXPECTATIONS OF CARE

In order for Dr. Greenberg to treat your chronic pain condition, the following expectations must be met:

Dr. Greenberg is in solo practice—while he makes every effort to remain available, there may be times during which he cannot be reached and you may have to seek temporary care through your primary care provider. Chronic pain is never an emergency. Do not call the office after hours or on weekends/holidays with chronic pain issues. New medical problems, or side effects from medications or treatments, however, may warrant urgent calls.
Medication refill requests should be made long in advance of running out of medication. The prescriptions may be post-dated to the due date. No refills of medications will be given after hours, during weekends, or holiday periods.
Irresponsible use of your medications may lead to running out early—Dr. Greenberg will allow you to go through drug withdrawal should this occur.
Lack of trust caused by misuse of medications or lack of compliance/ truthfulness is a breach of the therapeutic relationship and may lead to termination of care

I have read this document, understand it, and have had all questions

answered satisfactorily. I consent to the use of opioids to help control my pain, and I understand that my treatment with opioids will be carried out in accordance with the conditions stated above.

Patient:_____

Dare:_____