OCEAN Orthopedic ASSOCIATES

530 Lakehurst Rd, 1st Floor
Toms River, NJ 08755
732-349-8454

Name_____Account #: _____

OPIOID TREATMENT INFORMED CONSENT AGREEMENT

The purpose of this agreement is to prevent any misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treatment based on this agreement.

I understand that there is no cure at this time for my pain problem and there is no guarantee that long term opioid therapy will help me.

The following benefits, side effects, risks and terms of this agreement have been discussed with me and that by signing this agreement I understand and agree to the terms of this agreement.

Possible Benefits of long term opioid use include:

I understand that possible benefits of long-term opioid therapy include;

Improved state of control of pain and quality of life
Increased capacity for physical activity
Improved chance of returning to work
Improved sleep
Decreased reliance on other treatment modalities

Possible Risk/Problems of long-term opioid use include:

I understand that possible complications of long-term opioid therapy include:

Constipation	Decreased respiration
Reduce Sexual Function	Physical Dependence
Drowsiness	Chemical Dependence (addiction)
Nausea	Impaired Alertness
Itching	Impaired Physical Coordination

I understand that my physician and I will continuously evaluate the effect of opioids on achieving the treatment goals and make changes as needed.

I understand that my failure to meet these requirements may result in my provider choosing to stop writing opioid prescriptions for me. Withdrawal from the medications will be coordinated by the provider and may require specialist referrals. My provider will continue to treat me medically, but will not prescribe narcotic medication.

I understand that I may not be able to safely operate machinery or drive while taking opioid medications, particularly when I am started on medications or during dose adjustments. *I understand that I have to make honest, careful judgments about my state of alertness, response times, attention and physical coordination while taking this medication to minimize the risk of injury to myself and others.*

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Please initial before each number

_____ 1. I agree that I will not seek or obtain opioid prescriptions from any other physician(s) while I am under the care of my current physician.

_____ 2. I understand that if I do receive multiple opioid prescriptions from other facilities or physicians I will no longer be treated by this facility.

_____ 3. In the event of an emergency visit to a hospital emergency department, walk-in clinic or physician's office for injury or illness, I am responsible to disclose information about any additional opioid prescriptions provided to them at that time.

_____ 4. I will not give or sell my medication to anyone else, including family members; nor will I accept opioid medication from anyone else. I agree to be responsible for the secure storage of my medication at all times. If these medications are stolen, I will report this to the police and my provider and will produce a police report of the event if requested to do so.

_____ 5. I understand that if my prescription runs out early for any reason (for example, if I lose the medication or take more than prescribed); my provider may not prescribe extra medication for me. I may have to wait until the next prescription is due.

_____ 6. I will attend all appointments, treatments, and consultations as requested by my provider.

_____ 7. I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

_____ 8. I agree to use _____ pharmacy, located at _____, telephone number, for filling prescriptions of my pain medicine

_____ 9. I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ 10. I understand that the following recommendations made with regard to my treatment plan are meant to improve my level of functioning and quality of life. If I choose not to comply with these recommendations at any point, I will no longer be prescribed opioids.

_____ 11. I understand that the use of any mood altering substances, such as tranquilizers, sleeping pills, alcohol or illicit drug (such as cannabis, cocaine, heroin, or hallucinogens) can cause adverse effects or interfere with opioid therapy. Therefore, I agree to refrain from the use of all of these substances without prior agreement from my physician.

_____ 12. I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.

_____ 13. My provider may obtain information from State Controlled Substances databases and other prescription monitoring programs.

I agree to follow these guidelines that have been explained to me. All of my questions and concerns regarding treatment have been adequately answered.

Patient Signature: _____ Date: _____