**NARCOTIC ANALGESIC AGREEMENT / TREATMENT AGREEMENT**

**PATIENT NAME: _____ DATE: _____**

Since other treatments have not worked to control your pain, Dr. Arber has decided to place you on a trial of opioids to help manage your pain better and improve your social and work activities. This is a serious decision. This type of treatment does have risks,

most of which are listed below:

**RISKS:**

1. Constipation
2. Decreased appetite
3. Confusion or other changes in mental state or thinking ability
4. Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
5. Increased drowsiness
6. Breathing too slowly – overdose can lead to respiratory arrest and death
7. Physical dependence – abrupt stopping of the drug may lead to a withdrawal syndrome characterized by one or more of the following:
   a) runny nose
   b) diarrhea
   c) abdominal cramping
   d) "goose flesh"
   e) anxiety
8. Psychological dependence – stopping the drug will cause you to miss it or crave it
9. Tolerance – you need more and more drug to get the same effect
10. Children born to mothers on controlled substances are usually dependent on the drug at birth

## 11) OTHER SIDE EFFECTS INCLUDING DEATH FROM OVERDOSE OF THESE NARCOTICS.

**Dr. Arber will begin / continue treating you with narcotics (opioids) under the following set of conditions:**

1.) I have not responded to other reasonable forms of treatment or they have produced too many side effects.
2. I do not have problems with substance abuse or dependence.
3. I have never been involved in the sale, illegal possession, diversion, or transport of controlled substances (narcotics, sleeping pills, nerve pills, or pain killers), or deception to obtain these substances.
4. I will obtain all prescriptions for opioids from the Center for Diagnosis and Treatment of Pain.
5. I will use only one pharmacy for filling of prescriptions for opioids –
   Pharmacy Name: _____ #: _____.
6. I will take medications only as prescribed and under no circumstances allow other individuals to take my medications.

7. I will agree to allow my physician to communicate with my referring physician and any pharmacists regarding the use of controlled substances.
8. I will follow the advice of the physician in regard to stopping controlled substances, should he feel it advisable.
9. I will be required to have unannounced random blood and /or urine tests in order to properly assess the effect of the narcotics and my compliance.
10. If a female of childbearing ages, I will certify that I am not pregnant and that I will use the appropriate measures to prevent pregnancy during the course of my treatment with opioids.
11. I will notify The Center for Diagnosis and Treatment of Pain if additional narcotics are prescribed for treatment of other unrelated problems (emergency room, dentist, and other physicians).
12. **I UNDERSTAND THAT NO ALLOWANCE WILL BE MADE FOR LOST PRESCRIPTIONS OR DRUGS.**
13. **I WILL KEEP ALL MY SCHEDULED APPOINTMENTS WITH THE CENTER FOR DIAGNOSIS AND TREATMENT OF PAIN. (I WILL KEEP MY SCHEDULED APPOINTMENTS TO OBTAIN REFILLS.)**
14. **PRESCRIPTIONS WILL NOT BE REFILLED EARLY UNDER ANY CICUMSTANCES.**
15. **I UNDERSTAND THAT NO PRESCRIPTIONS WILL BE CALLED IN TO MY PHARMACY IN THE EVENINGS OR WEEKENDS.**

**I understand that this mode of treatment will be stopped if any of the following occur:**

a. If a physician feels that the opioids are not effective for my pain or that my functional activity is not improved.
b. I give, sell, or misuse drugs.
c. I develop rapid tolerance or loss of effect from this treatment.
d. I develop side effects that are significant in the view of a physician.
e. I obtain opioids from sources other than The Center for Diagnosis and Treatment of Pain.
f. I fail to comply with other parts of recommended treatment (behavioral pain management).

If we choose to discontinue your opioids, we will generally lower the dose slowly over several days. If we feel that you have a dependence problem, we may choose to refer you elsewhere for management of that dependency.

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**I have read this document, understand it, and have had all questions answered satisfactory. I will agree to the use of opioids to help my control of pain, and I understand that my treatment with opioids will be carried out in accordance with the conditions above.**

**Patient:** _____ **Date:** _____

**Witness:** _____ **Date:** _____