PATIENT CONSENT FOR TREATMENT WITH OPIOIDS

The caregivers at the Pain Specialists of Greater Chicago do at times need to utilize opioid medications to control acute, subacute, and chronic pain. I understand that I may require such medications now or in the future to control my pain. I understand that this consent is intended to deepen my appreciation for the possible consequences and complications of this course of treatment.

By signing this document, I attest that I am aware that the single greatest risk of utilizing opioids is the risk of ***accidental poisoning*** and ***death***. I understand that misuse or abuse can be associated with accidental poisoning but I am also aware that this terminal complication may occur even when using the medications compliantly. I understand that these pain medications are unique in that there can be a very small difference between the dose that provides pain relief and the dose that causes ***accidental poisoning*** and ***death***.

By signing this document, I attest that I understand that the risk of accidental poisoning is increased as the strength and/or dosage of the opioid is increased. I understand that the risk of accidental poisoning is increased when opioids are prescribed in conjunction with other medications that can depress the central nervous system including muscle relaxants, medications for anxiety and depression, and other medications. I understand that I must make the caregivers at PSGC aware of any and all medications I am taking and any new ones that are prescribed to me during my treatment.

By signing this document, I attest that I understand the risk of accidental poisoning is increased if alcohol or illicit medications are taken in conjunction with the opioids. I understand that I must make the caregivers aware of any illicit drug use and that I will discontinue such use while being treated with opioids. If I cannot accomplish this on my own, I will make PSGC aware so that they can help me find appropriate medical help.

By signing this document, I attest to the fact that I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction, and possibly that the medicine will not provide complete pain relief.

While I am taking opioid medications I agree not to be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. I understand that such activities include, but are not limited to: operating a motor vehicle, operating other equipment, working in unprotected heights or being responsible for an individual who is unable to care for him or herself.

I understand that the mere detectable presence of opioids in my bloodstream by a blood or urine test may cause legal entanglements. I understand that there is currently no acceptable minimal legal amount that could protect me from possible prosecution or lawsuits. I understand that this may occur even though these medications are prescribed by a physician. I understand that the caregivers of PSGC cannot condone operating heavy machinery while opioids are in my bloodstream.

I am aware that psychological addiction is defined as the use of a medicine even if it causes harm, having craving for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is low. I am aware that the development of addiction

is individually dependent and is much more common in a person who has a family or personal history of addiction. ***I agree to tell my doctor all information about my past use of recreational or illegal drugs and any excessive use of alcohol. I also agree to inform my doctor of any treatment I have had for alcohol or drug use and any incidents in my past in which medical providers have expressed concern over my use of alcohol, recreational drugs or prescribed medication. I also agree to inform my doctor of any drug use or excessive alcohol use in my family.***

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped or reversed by some of the medicines noted below, I will experience a medical condition known as withdrawal syndrome. This means I may have any or all of the following symptoms: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that certain other medicines such as nalbuphine (Nubain), pentazocine (Talwin) buprenorphine (Buprenex, Suboxone) and butorphanol (Stadol) may reverse the action of the medicine I am using for pain control. . I understand that taking any of these medications while I am taking my pain medications can cause symptoms like those of a severe flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell all doctors treating me that I am taking an opioid as my pain medicine and that I cannot take any of the medicines listed above.

I am aware that tolerance to analgesia means that after using opioid medications over time I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain however; it has been seen and may occur to me. If it occurs, increasing my dose of opioids may not help reduce pain but may cause unacceptable side effects. If I develop tolerance to opioids or if opioids do not seem to be helping my pain effectively I understand that my doctor may choose another form of treatment. I understand that the development of tolerance can lead to higher doses and strengths of opioid medications being required to control my pain. I understand that this increases the risk of accidental poisoning and overdosage.

(Males only) I am aware that chronic opioid use has been associated with my low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

(Females only) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that I should carry a baby to delivery while taking these medications; the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, I acknowledge that birth defects can occur whether or not the mother is on medicines and that there is always a possibility that my child will have a birth defect while I am taking an opioid medication.

I have read this form or have had it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing on the signature page, I give my consent for the treatment of my pain with opioid medicines.