pain consultants
OF WEST FLORIDA

PAIN MANAGEMENT AGREEMENT

MEDICALLY-INDICATED OPIOID ANALGESIC THERAPY FOR CHRONIC PAIN

INSTRUCTION: PCWFL is an interventional procedure-oriented practice that employs various pharmaceutical agents in conjunction with procedures and physical therapy, which intervene in pain pathways for the on-going management of chronic pain. PCWFL considers any opioid agent to be a last line therapy as its health risks mandate that it be prescribed at the lowest possible dose for the shortest time period. Please **review** each section for a full understanding of your responsibilities to the policies of this agreement, which provides for your safety and the safety of the public and **ask** any question of each section.

RISK _____ ***My initials indicate I have carefully read, fully understand, and agree to this section of the agreement.***

1.1 I understand and agree my opioid therapy presents potential risks to my health, which include, but are not limited to, addiction, addiction-relapse, bowel constipation/obstruction/perforation, cardiac event, confusion/delirium, depression, dizziness/imbalance, drowsiness/sleepiness, dry mouth, emotional anxiety/instability, fatigue, fetal addiction, immunity suppression, increased pain, liver dysfunction/damage, loss of effectiveness, mood change, nausea/vomiting, overdose, physical-dependence, psychological-dependence, respiratory depression/failure, sedation, sexual dysfunction, testosterone depletion, tolerance, weight loss/anorexia, withdrawal syndrome, and even DEATH.

1.2 I understand and agree opioid therapy with benzodiazepine therapy is potentially hazardous to my health, so either (1) my current benzodiazepine therapy will need to be discontinued by the prescribing physician, or (2) the prescribing physician must provide PCWFL with a letter of medical necessity for my benzodiazepine therapy for PCWFL to consider opioid therapy.

1.3 I understand and agree not to drive or operate machinery until such time that I know my opioid therapy does not cause sedation.

1.4 I understand and agree to disclose my opioid therapy to any other healthcare provider prescribing me a medication.

1.5 I understand and agree not to use Mitragyna speciosa (commonly known as Kratom)

1.6 I understand and agree not to use THC, Marijuana, CBD or any THC related products while taking Opioid Medications. This includes Medical and/or Recreational products.

1.7 I understand that PCWFL will address Pain Management related illnesses only and it is highly recommended I have and maintain a primary care physician

1.8 For Women: I will avoid getting pregnant while taking these medications. To the best of my knowledge, I am not pregnant at this time. I understand pregnancy tests may be completed by PCWFL.

SECURITY _____ ***My initials indicate I have carefully read, fully understand, and agree to this section of the agreement.***

2.1 I understand and agree I must provide security in a lock box for my opioid agent(s) as it is life-threatening to the health of others, especially a child.

2.2 I understand and agree if the prescription, or my opioid agent(s), is lost, stolen, or destroyed, a duplicate prescription may not be provided to me.

PRESCRIBER _____ ***My initials indicate I have carefully read, fully understand, and agree to this section of the agreement.***

3.1 I understand and agree while on my opioid therapy from PCWFL I will neither request nor accept prescribed opioid therapy from any other healthcare provider except -

3.2 I understand and agree I must inform the other healthcare provider of my opioid therapy; then, I may receive opioid therapy under these 3 situations:

(1) I am a patient of a healthcare provider in an emergency room of a hospital being treated for an acute emergency

(2) I am a patient of a healthcare provider in a hospital

(3) I am a patient of a healthcare provider having surgery

Under any 1 of these 3 situations, I must inform PCWFL of my receiving opioid therapy from another healthcare provider within 72 hours.

PRECRIPTION _____ ***My initials indicate I have carefully read, fully understand, and agree to this section of the agreement.***

4.1 I understand and agree I must follow exactly the prescribed instructions of my opioid therapy about the amount, route, and frequency of daily dosing.

4.2 I understand and agree I will not tamper with my opioid therapy by breaking, cutting, crushing, chewing, or smoking as this could lead to my DEATH.

4.3 I understand and agree that I will never apply direct heat (heating pad) over the skin patch of my opioid therapy as this could lead to my DEATH.

4.4 I understand and agree I am the sole user of my opioid therapy, such that I will not provide my opioid analgesic agent(s) to any other person.

4.5 I understand and agree I will not alter my prescriptions.

4.6 I understand that at any time there may be a shortage of my specific medication. It is my responsibility to manage my medication amounts until I am able to get a refill. I understand that these shortages affect many patients and PCWFL cannot manage persistent phone calls regarding this matter. In an attempt to assist every patient in this situation, I understand that PCWFL will only accept 1 phone call per day regarding a pharmacy change for out-of-stock medications. I understand that it is my responsibility to find my medication in stock at a pharmacy. Failure to do so will result in an in-person office visit so that a weaning dose of medications can be prescribed, to prevent withdrawals in an opioid shortage.

4.7 I understand medications cannot be altered over the phone and require an in person visit.

PHARMACY _____ ***My initials indicate I have carefully read, fully understand, and agree to this section of the agreement.***

5.1 I understand and agree I must declare an independent single dispensing pharmacy of my choosing that will be the sole dispenser of my prescribed opioid therapy.

REFILL _____ ***My initials indicate I have carefully read, fully understand, and agree to this section of the agreement.***

6.1 I understand and agree a request by me for an early refill of my opioid therapy prior to the scheduled refill date as outlined by my overall treatment plan may be denied.

6.2 I understand and agree I must not request a refill of my opioid therapy outside the operational hours of the clinic (Monday – Friday; 8:00 AM – 5:00 PM), such as after hours during the evening/night or over a weekend/holiday.

TREATMENT PLAN _____ ***My initials indicate I have carefully read, fully understand, and agree to this section of the agreement.***

7.1 I understand I must comply with the treatment plan as outlined**.**

7.2 I understand and agree continuance of my opioid analgesic therapy is dependent on maintaining my monthly follow-up re-evaluation as defined by my overall treatment plan for the continued re-assessment and risk re-evaluation of this class of therapy.

7.3 I understand I may see a physician assistant or nurse practitioner for some follow up visits**.**

7.4 I understand I must call 48 hours prior to my appointment time if I need to cancel to avoid a cancellation fee and that I must manage my medication quantity until my rescheduled appointment date.

7.5 I understand that failing to arrive for my appointments at my scheduled arrival time may result in the appointments being rescheduled and a fee may be incurred for missing the appointment. Multiple occurrences of missing an appointment or being late may result in discharge from the practice.

ACCOUNTING _____ ***My initials indicate I have carefully read, fully understand, and agree to this section of the agreement.***

8.1 I understand and agree that, if requested, to bring my opioid agent(s) in original container(s) for an accounting of the agent(s) within the specified time given by PCWFL.

TESTING _____ ***My initials indicate I have carefully read, fully understand, and agree to this section of the agreement.***

9.1 I understand I may be assessed to monitor for abuse, addiction, or misuse.

9.2 I understand and agree I must provide testing of my blood, or urine while on my opioid therapy, in which, the absence of my opioid therapy or the presence of any unauthorized or illegal substance(s) in my sample may result in the immediate termination of my opioid therapy.

DURATION _____ ***My initials indicate I have carefully read, fully understand, and agree to this section of the agreement.***

10.1 I understand and agree the goal of my opioid therapy for pain relief is for me to be on the lowest possible dose for the shortest possible period of time.

10.2 I understand and agree justification for continuing my opioid therapy depends on me communicating with my provider the character and intensity of my pain, the effects of the pain on my daily life, and how well the medicine is helping relieve the pain.

PRIVACY _____ ***My initials indicate I have carefully read, fully understand, and agree to this section of the agreement.***

11.1 I understand and agree to the release of any and all details of my personal healthcare information by PCWFL to any healthcare provider; any dispensing pharmacist; any law enforcement agency; and/or, any regulatory board for the purpose of investigating the possible abuse, misuse, or diversion of my opioid therapy.

TERMINATION _____ ***My initials indicate I have carefully read, fully understand, and agree to this section of the agreement.***

12.1 I understand and agree my opioid therapy will be terminated should I fail to comply with the policies of this important agreement.

12.2 I understand and agree my failure to comply with the policies of this agreement may result in my being referred to a detoxification program.

I have read each section of this patient–physician agreement regarding my medically-indicated opioid therapy. I fully understand each section and voluntarily agree with all the policies contained within this patient–physician agreement with PCWFL for the safe relief of my pain.

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Patient Signature

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Patient Name (Print) Date