



## Orthopaedic Associates, L.L.P

### Contract for Opioid Therapy

Our policy regarding the prescription of opioids for nonmalignant pain is strict and non – negotiable. Narcotics should only be used as an adjunct to other therapies and as a last resort after other treatment modalities have failed.

Our objective when prescribing narcotics are:

- To provide adequate analgesia with the least dose possible.
- To minimize side effects.
- To allow you to become more functional.
- To avoid abuse and addiction.

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#### Please read the following 20 statements listed below

1. The goal of my medication plan is to discontinue the use of short action opioids (Vicodin, Lortab, Lorcet, and Norco) for chronic pain conditions.
2. Prescription refills will be done on an as needed basis, but no sooner than 10 (ten) days.
3. No refills will be made after clinic hours and on weekends or holidays.
4. I will use my medication only as prescribed. I will not take more than the amount indicated. Any evidence of such may result in termination of patient-physician relationship in OA.
5. I will not share my medications with anyone.
6. If I lose my medication, my prescription will not be replaced. Only in the event of extraordinary circumstances an exception will be made (i.e. your house burns down or you have a police report).
7. If my prescription is not refilled, I might experience a withdrawal syndrome. This means I may have any or all of the following: 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 may choose to seek medical attention at an emergency room.
8. While being a patient at OA, I will not receive prescriptions for opioids or other sedatives from any other licensed physician, unless it is authorized by OA. Any evidence of such will result in termination of the patient-physician relationship in OA.
9. I will not alter nor forge my prescriptions. Any evidence of such will result in termination of patient-physician relationship in OA.
10. I will use only **1 (one)** pharmacy to fill my medication.
11. I agree to provide a sample of my urine, and in some cases blood, for drug screening at my physician's request. Failure to do so will result in termination of the patient-physician relationship in OA.

12. Findings of other non-prescribed drugs in my urine or blood will result in termination of the patient-physician relationship in OA.
13. I am aware that **addiction** is defined as the use of a medicine even if it causes harm, having cravings 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 medication is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest drug history and that of my family to the best of my knowledge.
14. I understand that physical **dependence** is normal and expected result of using medicines for a long time. Dependence is not the same as addiction. I am aware physical dependence means that if pain medicine use is markedly decreased, stopped, or reversed by some agents (nalpuphine, buprenorphine, or stadol) I will experience withdrawal symptoms.
15. I am aware that **tolerance** to analgesia means that I may require more medicine to get the same amount of pain relief. Tolerance does not seem to be a big problem for most patients. If it occurs, increasing doses may not always help and may cause unacceptable side effects. This may cause my doctor to switch to another opioid or choose another form of treatment.
16. I am aware that the use of opioids has been associated with the following side effects:
- Sleepiness and drowsiness
  - Nausea
  - Vomiting
  - Constipation
  - Urinary retention
  - Dizziness
  - Itching
  - Allergic reaction
  - Slow breathing/Slow reflexes and reaction times
  - Low testosterone levels in males
17. If the medications cause dizziness, sedation, or drowsiness, I understand I must not drive a motor vehicle or operate machinery that could put my life or someone else's in jeopardy.
18. Overdose of this medication may cause **death** by stopping my breathing.
19. I have read this contract or had it read to me. I understand all of it. I have had the chance to have all of my questions regarding this statement answered to my satisfaction. By signing this form voluntarily, I give ORTHOPAEDIC ASSOCIATES, L.L.P. my consent for the treatment of pain with opioid medications.
20. If I violate this agreement, my doctor will discontinue this form of treatment.

Patients Name: \_\_\_\_\_

Patients Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone #: \_\_\_\_\_