Family Health Center
Informed Consent Opioid Therapy

I consent to treatment with Opioids medication, sometimes called Narcotic Analgesics for my intractable pain. This decision to treat the pain was made because my condition is serious or other treatments had not helped my pain. I am aware that the use of such medication has certain risks associated with it, including but not limited to increase thyroid hormones, increased prolactin hormones, endocrine hormones, sleepiness, 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 possible that the medication will not provide complete pain relief. I am aware of possible risks and benefits of other types of treatments that do not involve the use of Opioids. The other treatments discussed with me by the doctor include NSAID's, Acetaminophen and adjuvant therapies such as antiepileptic, calcium channel blockers, sodium channel blockers, non-pharmacological therapies, electrical therapy, acupuncture, hypnosis, counseling, medications, biofeedback, physical therapy, chiropractic therapy and others. I will not 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. Such activities include but are not limited to: operating heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for him/herself. I will keep my medication out of the hands of children and other people knowing that it could cause them harm.

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 more common in a person who has a family history of addiction 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.

I understand that physical dependence is a normal, expected result of using these medications for a long period of time. I understand that physical dependence is not the same as addiction. I am aware that physical dependence means that my pain medications is markedly decreased, stopped or reversed by some of the agents mentioned above. I am aware that I will experience withdrawal syndrome. This means may have any or all of the following symptoms: runny nose, yawning, large pupils, good bumps, abdominal pain, cramping, diarrhea, irritability, aches throughout my body and a flu like feeling. I am aware that tolerance to analgesia means that I may require more medicines to get the same amount of pain relief. I am ware 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 tolerance occurs, increasing dosages may not always help and can cause unacceptable side effects. Tolerance or failure to respond well to Opioids may cause my doctor to choose another form of treatment.

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**Males Only: I am aware that chronic Opioid therapy has been associated with low testosterone levels in males. This may affect my mood, sexual desire, physical and sexual 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 have reason to believe that I have become pregnant while taking this pain medication, I will immediately inform my OBGYN. I am aware that should I carry a baby to delivery while taking these medicines, the baby will be dependant of Opioids. I am aware that the use of Opioids is not generally associated with risks of birth defects; however, birth defects can occur whether or not the mother is on medication and there is always the possibility that my child will have a birth defect while I am taking Opioid medication.

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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 this form voluntarily, I give consent for the beginning or continuing therapy with Opioid Treatment Medications.
My diagnosis being treated is listed in my clinical notes.

Patient Signature_____ Date_____
Witness Signature_____ Date_____