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Paradise Valley Pain Specialists

Paul Wang, D.O.
Fellowship-trained in Pain Management
Board-certified in Physical Medicine & Rehabilitation

Patient Name: DOB:

Informed Consent and CONTROLLED SUBSTANCE Trilateral Agreement

Informed Consent

The purpose of this form is to inform the patient regarding the use of opioid medications for the treatment of pain and to assure that the patient and the physician comply with state and federal regulations concerning the prescribing of opioid medications. The physician's goal is to assist the patient in achieving the best possible quality of life given the reality of the clinical condition to be treated. A trial of opioid therapy is being undertaken as part of an overall treatment plan in order to reduce pain and increase the patient's functional capacity.

Risks of opioid therapy include but are not limited to side effects such as constipation, skin rash, pruritis (itching), sexual dysfunction, sleeping abnormalities, sweating, and edema (swelling). This class of drugs may cause confusion, drowsiness, sedation (potentially excessive), and the possibility of impaired cognitive (mental status, thinking) and motor (movement, coordination) ability. This may make it unsafe for you to drive a vehicle, operate hazardous equipment or do other dangerous activities. Under Arizona State Law Title 28 Chapter 4 Article 3 "It is unlawful for a person to drive or be in actual physical control of a vehicle in this state under the influence of intoxicating liquor, and drug, a vapor releasing substance containing a toxin or any combination of liquor, drugs, or vapor releasing substances if the person is impaired to the slightest." In Arizona this may be ground for prosecution of a DWI offense ____ (Initials)

Overuse or overdose of opioids can lead to profound sedation, respiratory depression (decreased breathing), coma, and death. Opioid maintenance therapy causes physical dependence. This means that if opioid medications are abruptly stopped or if the dose is reduced significantly over a short period of time, the patient can experience a withdrawal syndrome. This is a normal physiologic response. The withdrawal syndrome can include, but is not limited to, symptoms such as nervousness, irritability, insomnia, rhinorrhea (persistent watery discharge from the nose), excessive tearing, sweating, "gooseflesh", abdominal cramps, nausea and or vomiting, diarrhea, and a craving for the drug.

The patient should understand that physical dependence is not the same as addiction. The use of opioid medications can increase the possibility of relapse for a patient with a history of addiction or alcoholism. Such history does not disqualify a patient from opioid therapy for pain. The patient should understand that tolerance could occur with opioid maintenance therapy. This means that the effects and side effects of the drug may decrease over time sometimes making dosage adjustment necessary. Long acting opioid drugs decrease the rate at which tolerance develops.

Controlled Substance Trilateral Agreement

This agreement relates to my use of controlled substances for chronic pain prescribed by a physician at Paradise Valley Pain Specialists (PVPS). I have been informed and understand the policies regarding the use of controlled substances that are followed by the staff at Paradise Valley Pain Specialists.

If the treating pain physician at PVPS thinks you may be a candidate for opioids or other controlled substances, they may require a psychiatric evaluation before deciding to prescribe. The pain physician will then prescribe medications until you are on a stable dose. The treatment goal is not 100% pain relief. The treatment goal is a moderate degree of pain relief that results in improvements in function. It is possible that you cannot be stabilized on medications and controlled substances may then be withdrawn.

Once you are on a stable dose, your primary care physician (and you must have one) agrees to refill your prescription(s) monthly. You must see the pain physician at least once every six months to reevaluate your progress with treatment. Your primary care physician must also agree to all of the terms of this agreement.

I understand that I will be provided controlled substances while actively participating in this program only if I adhere to the following conditions:

OFFICE COPY

PLEASE READ AND ATTEST TO THE FOLLOWING STATEMENTS:

T F 1. I have not responded to other reasonable forms of treatment or they have produced too many side effects.

T F 2. I do not have problems with substance abuse.

T F 3. I have never been involved with the sale, illegal possession, diversion or transport of controlled substances (narcotics, sleeping pills, nerve pills or pain killers) or deception to obtain these substances.

T F 4. I will obtain all prescriptions from _____ at Paradise Valley Pain Specialists or my primary care physician _____.

T F 5. I will take pain medicine only as prescribed by Dr. _____ and under no circumstances allow other individuals to take my medications nor will I take medication prescribed to another person.

T F 6. I agree to allow Paradise Valley Pain Specialists to communicate with physicians involved in my care and any other related healthcare professional (nurses, pharmacists, emergency services, etc.) regarding my use of controlled substances.

T F 7. I will follow the advice of my physician in regard to stopping controlled substances, should he/she feel it advisable.

T F 8. I agree to submit to unannounced random pill counts or random urine or blood tests in order to properly assess the effect of the narcotics and my compliance.

T F 9. If a female of childbearing age, I certify that I am not pregnant and that I will use appropriate measures to prevent pregnancy during the course of treatment with opioids.

T F 10. If a male, I am aware that chronic opioid use has been associated with low testosterone levels. This may affect my stamina, libido, physical and sexual performance, and mood.

T F 11. I understand that I will not receive replacement medications for any medications, which I have lost or have been stolen.

T F 12. I will notify my doctor if additional opiates are prescribed for treatment of other unrelated problems (emergency room, dentist, and other physicians) within 48 hours.

T F 13. If my doctor recommends, I will see a specialist for the determining whether I am developing an addiction.

T F 14. I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy and behavioral medicine strategies. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the Pain Management Program to maximize functioning and improve coping with my condition.

T F 15. There will be no alcohol or illicit drug use while taking narcotic medications. Discovery of such via internal or external sources may result in discontinuation of narcotics immediately.

T F 16. I understand that driving or operating machinery while taking narcotics may have untoward consequences, and if I elect to operate machinery or equipment, I do so at my own risk of injury or death.

T F 17. I will accept generic brands of my prescription medication.

T F 18. I agree that if I change my primary care physician and my new physician will not agree to the trilateral agreement, I agree to discontinue opiate therapy.

T F 19. I will not expect to receive additional medication prior to the time of my next scheduled refill, even if my prescription runs out.

T F 20. I agree to schedule and keep follow-up appointments with my Paradise Valley Pain Specialists physician and primary physician at recommended intervals. I understand that failure to keep appointments may lead to discontinuation of treatment.

T F 21. If it appears to the physician that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will gradually taper my medication as directed by the prescribing physician.

T F 22. I agree to submit to urine and blood screens to detect the use of non-prescribed medications (including "street" drugs) at any time.

OFFICE COPY

T F 23. I understand that my doctor will not be available to prescribe medication during evenings and weekends. My doctor's partners will not provide me with refills by phone especially at night or on weekends. It is my responsibility to call my doctor at least 3 business days in advance of running out of medications.

T F 24. I will use only one pharmacy for filling of all of my prescriptions except in case of emergency:
Pharmacy Name: _____ Phone: _____
Address: _____ Zip Code: _____

T F 25. I am responsible for keeping track of the amount of medication left and to plan ahead for arranging the refill of my prescriptions in a timely manner so I will not run out of medications.*

T F 26. If the violation involves obtaining controlled substances or any prescription for my pain condition from another individual or if I engage in any illegal activity such as altering a prescription, I understand that the incident may be reported by Paradise Valley Pain Specialists to other physicians caring for me, local medical facilities, pharmacies and other authorities such a the local police department, Drug Enforcement Agency, etc. as deemed appropriate for the situation.

T F 27. If I violate any of the above conditions, my obtaining prescriptions and/or treatment at Paradise Valley Pain Specialists may be terminated.

*MEDICATION REFILL INFORMATION:

A. Advance notice of 3 business days is required for refills of prescriptions.
B. Requests for scheduled refills must be telephoned to 602-494-5015. Refills will not be made at night, on holidays, or on weekends.
C. Most controlled substances cannot be telephoned in to a pharmacy. You must make arrangements to pick up your prescription during regular business hours.

THIS AGREEMENT WILL SUPERSEDE ALL OTHER AGREEMENTS.

BY SIGNING BELOW I INDICATE THAT I UNDERSTAND AND AGREE TO ALL THE TERMS OF THE ABOVE AGREEMENT. BOTH YOU AND YOUR PRIMARY PHYSICIAN MUST SIGN AND AGREE. I HAVE RECEIVED A COPY OF THIS FOR MY OWN RECORDS.

Patient (or Guardian) Signature Date

Pain Management Physician Date

Primary Care Physician Date

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Patient (or Guardian) Signature Date

Pain Management Physician Date

Primary Care Physician Date