VOYTIK CENTER FOR ORTHOPEDIC CARE

VCOC

Patient's Consent to Receive Opioid Therapy

I, _____ understand the Voytik Center for Orthopedic Care is recommending opioid medication to treat the pain I have due to my following condition(s) _____ (diagnosis).

I have told my physician about all other medicines and treatments that I am receiving, and I will promptly let my physician know if I start to take any new medications or new treatment. I have also discussed my complete personal drug history and that of my family with my physician.

I understand that opioid medication is being recommended because my pain complaints are moderate to severe and other treatments have not sufficiently help my pain. I understand that many medications can have interactions with opioids that can either increase or decrease the opioid's effect on me.

It has been explained to me that the initiation of an opioid medication is a trail. Continuation of the medication is based on evidence of benefit to me, a lack of harmful side effects, and me following instructions on the usage of the medication. Continuation and any changes in dosage of the opioid medication will be determined by my physician based on information and if I have lack of significant improvement, the development of harmful side effects, or other considerations, my physician may stop using this treatment or change dosage.

It has been explained to me that taking narcotic/opioid medication may pose certain **risks and side effects**. These **risk and side effects** include, but are not limited to:

- Addiction and/or Overdose (which could result in harm or death)
- Slowing of breathing rate
- Slowing of reflexes or reaction time
- Sleepiness, drowsiness, dizziness and/or confusion
- Impaired judgement and inability to operate machines or drive
- Nausea, vomiting and/or constipation
- Allergic reaction or Itching
- Failure to provide pain relief
- Changes in hormonal levels and/or changes in sexual function (This is generally caused by reduced testosterone levels. Such reduced levels may affect mood, stamina, sexual desire and physical and sexual performance)
- Physical dependence or tolerance to the pain-relieving properties of the medication (This means if my medication is stopped, reduced in dose, or rendered less effective by other medications I may be taking, I may experience runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and flu like feelings. This can be very painful but are generally not life-threatening)
- Dangers to others if they get access to opioids including overdose, addiction or even death.
- Certain medications such as nalbuphine (Nubain™), Pentazocine (Talwin™), Buprenorphine (Burprenex™), and Butorphanil (Stadol™), may reverse the action of the opioid and cause symptoms like a bad flu, called a withdrawal syndrome.

Patient Consent

I have been informed of the risk and potential benefits of opioid medications and possible alternative treatments, having had the characteristics, expectations and how opioids should be used and having given the opportunity to discuss options and ask any question that I may have, I agree that any questions that have raised have been discussed to my satisfaction. Therefore, ***I voluntarily consent to take opioid medication***.

I will take this opioid medication only as prescribed and I will not change the amount of dosage frequency without authorization from my physician. I further understand that changes may result in running out of medication early and early refills may not be allowed. I also understand that if I do not take the medication correctly, I may have withdrawal reactions that may include stomach pain, sweating, anxiety, nausea, vomiting and general discomfort.

I agree not to take nalbuphine (Nubain™), Pentazocine (Talwin™), Buprenorphine (Burprenex™), and Butorphanil (Stadol™), while I am taking an opioid and I further agree to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed here.

I will fill my opioid medication at one pharmacy _____ (name) _____(number). I hereby authorize my physician to discuss all diagnostic and treatment details of my condition with the pharmacists at the pharmacy listed above.

I will submit to random pill counts and urine and/or blood drug screens as requested by my physicians in order to monitor my treatment. I understand that the presence of any unauthorized substances in my urine or blood may prompt a referral for assessment of addiction or chemical dependency and could result in discontinuation of further opioid prescriptions. I also understand that failure to allow these rules may lead to no longer being treated by my physician after a 30-day, emergency only period.

I will not share, sell or otherwise permit others to have access to my medication and I will keep it in a secure location.

I have Read this form, or had it read to me. I understand all the information and policies. Any question I may have had have been answered to my satisfaction. By signing this form, I voluntarily give my consent for the treatment of my pain with opioid pain medicine. I understand and agree that failure to follow these policies will be considered noncompliance and may result in stopping opioid prescribing by my physician and possible dismissal from care.

_____ Date: _____
Patient or Guardian Signature

_____
Patient or Guardian Printed Name

For Women of Childbearing Age Only (*under Tennessee law, ages 15-44*)

Risks associated with opioid use during pregnancy
It has been explained to me that the use of narcotic/opioid medication poses special risks to women who are pregnant or may become pregnant. I have been advised, for example, that should I carry a baby to delivery while taking this medication, the baby will be physically dependent on opioids (called: Neonatal abstinence Syndrome"), which is very harmful to the baby. I also understand that birth defects can occur to the baby whether or not the mother is on medication and there is always the possibility that the baby will develop a birth defect while I am taking an opioid. Furthermore, I recognize that the long-term consequence on a child's development who was exposed to opioids is not fully understood and cannot be predicted, but it could be harmful to the child. If I plan to become pregnant of believe that I have become pregnant while taking opioid medication, I will immediately call my obstetrician and this office to inform them.

It has been explained to me that there are other treatments that do not involve use of narcotic/opioid medications. I have had the opportunity to discuss these options with my physician and to ask any questions about them which have all been answered to my satisfaction.

Birth Control Counseling
I understand I should use birth control to reduce the chances that I become pregnant while being treated with narcotic/opioid medication. I understand I can contact the local Health Department about how I can receive free or reduced birth control.

Date: _____

_____ _____
Signature of Patient or Guardian Signature of Patient if a minor

_____ _____
Printed Name of Patient or Guardian Printed Name of Patient if a minor

Note: Nothing prohibits a physician from advising, counseling or providing information directly to a competent and mature minor patient. (TCA 53-11-308).

07.25.18