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Douglas J. Abeles M.D.

Informed Consent Prescription Guidelines for Patients

The goal of pain management is to manage your pain and improve function not eliminate pain

1. You may be put on opioids on trial basis. Of pain and function does not improve you may be taken off these medications. In this case you will be weaned off narcotics under medical supervision.

2. **PATIENT REMINDER:** You have signed an agreement with the office which states: "agree that refills of my prescription for medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or weekends".

3. Patients are required to safeguard their medicine from loss or theft. Lost or stolen medicine will not be replaced. Please do not carry your entire bottle full of medicine around, only your day's supply.

4. Even at home keep your narcotics locked up. Many stolen prescriptions occur from the medicine cabinet at home.

5. If you have a flare-up requiring more medication you may use more medication but will have to correspondingly reduce that medication use after the flare-up subsides so that you do not run out early. We will not fill early medication.

6. Any changes in dosage regimen can only be made after permission from the doctor. Patients are responsible for scheduling an appointment before their medications run out.

7. Please note, there is a potential to become addicted to narcotics. You will develop a dependence on narcotics if you take it long enough.

8. Please note, stopping opioids suddenly may result in withdrawal (due to physical dependence) symptoms. Hence getting off narcotics should be under medical supervisions.

9. Please bring all current medications, especially those prescribed by other physicians to office appointments. The purpose is to check current medications, dosages and drug interactions.

10. You may be subject to urine or blood toxicology screens as needed to ensure compliance with your treatment program.

11. If you use recreational drugs or medicinal marijuana we need to know about this up front.

12. You are not to obtain similar medications from other physicians. Doing so may result in discharge from our practice.

13. You will agree to submit to psychiatric testing or consultation to assess appropriateness of long term narcotic therapy.

14. Please check prescription bottles for any additional refills. If there are refills remaining, please contact the pharmacy directly, they should automatically refill the prescription on the due date.

15. **PLAN AHEAD.** Request a medication at least three days in advance to prevent running out of medication. Pay attention to Holidays and dates the office will be closed.

16. When there are no refills remaining please call the office and schedule an appointment with a physician. Patients are required to see a physician before receiving more medications.

17. Patients are expected to actively participate in improving function and provide us with documentation of this improvement.

Patient Name: _____ **Patient Signature:** _____

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Pain Management Agreement

The purpose of this agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based in this agreement.

I understand that I am being placed on these medications on a trial basis initially for 3 to 4 months. If my pain and function does not improve, I may be taken off these medications. I understand that these medications **will** cause physical dependence and **may** cause addictions.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve pain.

I will not use any illegal controlled substances, including marijuana, cocaine etc. I will not share, sell or trade my medication with anyone. I will not attempt to obtain any controlled substances, including opioid pain medicines, controlled stimulants from any other doctor. I will keep my doctor informed about all other medications I am taking and about all other doctors I am seeing.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.

I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends. I am responsible for making my next appointment ahead of time, in time for mu next refill. I understand that if I do not make timely appointments I run the risk of running out of medications and going into withdrawals.

I understand that any change in dosage regimen can be made only after permission from the doctor. If I have been allowed to increase the dose it is my responsibility to call the office and reschedule my appointment so that I don't run out of medications.

I agree to use _____ Pharmacy, located at _____
Telephone number_____ for filling prescriptions for all my pain medications.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. Further if necessary the doctor is authorized to discuss medication issues with my family members and other health care professionals to ensure compliance with my pain program.

I agree that I shall not go to the emergency department for pain control issues seeking opioids. I understand that I can and may use the emergency department for other emergencies. I agree that I will submit to a blood or urine test if requested by my doctor to determine compliance with my program of pain control medicine.

I agree that I will use my pain medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unused pain medicine to every other office visit.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of the document has been given to me.

This agreement is entered into on this day of _____

Patient name: _____ Signature: _____

Physician Signature: _____ Witnessed By: _____