TRIANGLE
PAIN INSTITUTE

Triangle Pain Institute
2605 Blue Ridge Rd
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Raleigh, NC 27607

Phone: 919-615-0018
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Website: www.trianglepaininstitute.com

Opioid Use Agreement

Risk and Safety Information:

I know that opioid treatment for chornic pain is used to redue cpain and imprve daily function. Prior to and along with opiod treatment, other medical care indlucing exercise, non-narcotic analgesics, physical therapy, psychological counseling may be prescribed to help improve my ablility to do daily activities. I know that opioid therapy will not get rid of all my pain and will not cure me. I know there is danger associated with the use of opioids while operating heavy equipment or driving.

I have been informed there are risks to taking opioid medications including addiction, physical dependence, withdrawal that may occur upon abruptly stopping these medications, giving birth to babies with wirthdrawal symptoms if taken while pregnant, repiratory depression, and death.I am aware the side effects that may occur from opioid therapy include nausea/vomiting, confusion, loss of balance, shortness of breath or slow breathing, addiction, sexual dysfunction, decreased testeosterone, and withdrawal

Signs of Withdreawal: Diarrhea, stomach cramps, goose-bumps, flu-like symptoms, body aches, shaking, fast heart rate, and feeling anxious or on edge.

Agreement Terms:

I understand and accept that if I do not follow the guidelines below my provider may no longer prescribe opioids and/or may discharge me from the practice. I understand if that occurs I will need to find another care provider.

Guidelines:

1. I will take medications on ly at the dose and frequency prescribed. If I want to changed how much or how often I take medications I will get my providers approval first during office hours.
2. I will not incrase or change medications without the approval of this provider
3. I will not share, sell or trade any of my medications and will not use anyone else's medication.
4. I will not request or use opioid medications from physicians other than from this provider unless prior authorization was obtained from this provider
5. I will be honest and inform this provider of all medications that I am taking at each visit
6. I will bring all my medications in the orginial bottles to all office visits.
7. I will allow my blood, urine, or oral fluid to be tested. I will not be told when the test will occur.
8. I consent to random drug screening and pill counts and understand I may be called to the office on short notice for either
9. I will tell my provider names of all previous treating providers and of all medications and doses used in the past.
10. I will obtain all medications from on pharmacy and give full consent by signing this agreement for this provider.
11. I will protect my prescriptions and medications to make sure they are not lost or stolen. I will keep all medications away from children and locked in a safe place.
12. I will be honest with my provider about medications I am taking and the use of illegal drugs.
13. I will not drink alcohol or use illegal street drugs while being prescribed opioid medications.
14. If I am found to have an addiction problem after opioid therapy is initiated, it will be discontinued and my provider may ask me to follow through with a program to address the issue such as counseling or inpatient/outpatient treatment/rehabilitation.

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15. I will tell my provider about current medical, emotional, and mental problems and I agree to participate in psychological assessments, if necessary.
16. I will actively participate in return to work efforts and in any program designed to improve function including social, physical, psychological, and daily or work activities.
17. I will have the tests, other treatments, and consults my provider suggests.
18. I understand that in documented emergency situations that it may be necessary for an emergency room physician or other provider to prescribe opioid medications. I am responsible for signing consent to have those records transferred. I am also responsible for making sure that no more than 5 days of medication is prescribed by any treating physician in this situation.
19. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.
20. I understand it is my responsibility to make sure appointments are made prior to running out of medication. I know medications will not be refilled if an appointment is missed or rescheduled by me.
21. If my medications runs out early, I will have to wait until it is time for another refill.
22. I understand lost or stolen prescriptions will not be replaced. No exceptions.
23. I will not alter or copy my prescriptions in any way.
24. My provider may talk with any doctor, provider, or pharmacist about my opioid agreement and treatment.
25. I am not pregnant and agree to do what I can to prevent becoming pregnant. If I become pregnant I will notify my provider immediately.
26. I understand opioid therapy will be stopped if:
    a. I do not follow the above guidelines
    b. I give, sell, or misuse the opioid medications/prescriptions
    c. I obtain opioids from another provider.
    d. I refuse a pill count or drug screen.
    e. An addiction problem is identified.
    f. My provider determines this treatment is ineffective for my pain.
    g. My provder determines my functional activity is not improved
    h. I develop rapid tolerance or lost effect from treatment
    i. I developed significant side effects
    j. I am unable to keep follow-up appointments.

I have read and understand the agreement above. All of my questions have been answered. I consent to the use of opioid medications to help control my pain and I understand that my treatment with opioids will be discontinued and I may be dismissed as a patient if one or more of the above guidelines are not followed.

_____ _____
Signature of Patient Date

_____
Print Full Name

_____ _____
Witness Date