PATIENT MRN: _____

PHYSICIAN: _____

INTEGRATED PAIN ASSOCIATES

PAIN MANAGEMENT SPECIALISTS

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT
-AS REQUIRED BY THE TEXAS MEDICAL BOARD

REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170
3rd Edition: Developed by the Texas Pain Society, April, 2008 (www.texaspain.org)

NAME OF PATIENT: _____DATE: ____ / ____ / _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used so you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm, but rather it is an effort to make you better informed so you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this Agreement, the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain. It has been explained to me these medication(s)/controlled substances include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand these medication(s) may lead to physical dependence and/or addiction and can, like other drugs used in the practice of medicine, produce adverse side effects or results. In some cases, controlled substances are used to treat chronic pain and related to anxiety and depression, these substances are strictly regulated by both state and federal agencies. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand this listing is not complete, and it only describes the most common side effects or reactions, and death is also a possibility as a result from taking these medication(s).

I HAVE BEEN INFORMED AND understand I will undergo medical tests/be required to complete needed radiographic imaging and complete examinations before and during my treatment. Those tests can include random unannounced urinalysis testing and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from your care.

- For female patients only:
- **To the best of my knowledge, I am NOT pregnant.**
- **I accept that it is MY responsibility to inform my physician immediately if I become pregnant.**

All of the above possible effects of medication(s) have been fully explained to me and I understand, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/fetus/baby.

I UNDERSTAND THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension (low blood pressure), arrhythmias (irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain once examined and approved with my provider.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so I can enjoy an improved quality of life. I realize the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and I will notify my physician of any discontinued use. I further understand I will be provided medical supervision if needed when discontinuing medication use.

I understand no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe I have sufficient information to give this informed consent.

I have been given the opportunity to ask any questions about my chronic pain and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s)

I UNDERSTAND AND AGREE TO THE FOLLOWING:
This Pain Management Agreement relates to my use of any and all medication(s)/controlled substances (i.e., opioids, also called "narcotics, painkillers", and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand there are federal and state laws, regulations, and policies regarding the use and prescribing of controlled substance(s). Therefore, medication(s) may be provided, per our treatment guidelines, so long as I follow the rules specified in this Agreement.

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My physician may, at any time, choose to discontinue medication(s)/controlled substances. Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if medication(s) are not improving my quality of life, the medication(s) may be discontinued.
- I will disclose to my physician all medication(s) I take at any time, prescribed by any physician. I understand that a PMP report may be generated for review at any time.
- I will use the medication(s) exactly as directed by my physician. I will NOT self-medicate.
- I agree not to share, sell, or otherwise permit others, including my family and friends, to have access to these medications.
- I will not allow or assist in the misuse/diversion of my medication; nor will I give or sell them to anyone else.
- All medication(s) must be obtained at one pharmacy, where possible. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and will provide my pharmacist a copy of this Agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I understand my medication(s) will be refilled on a regular basis. I understand my prescription(s) and medication(s) are exactly like money. If either are lost or stolen, they MAY NOT BE REPLACED.
- Refill(s) will not be ordered before the scheduled refill date. However, early refill(s) may be allowed when I am travelling and arrangements are made in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) from only ONE physician unless it is for an emergency or the medication(s) being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician there are no demonstrable benefits to my daily function or quality of life from the medication(s), then my physician may try alternative medication(s) or may taper me off all medication(s). I will not hold my physician liable for problems caused by the discontinuation of medication(s).
- I agree to submit to urine and/or blood screens to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc. treatment for chronic pain may be terminated.
- I agree to random pills counts at any time and without prior warning. If I have not provided my medication(s) within the time permitted by my provider, treatment for chronic pain may be terminated.
- Also, a consult with or referral to an expert may be necessary such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an Addiction Specialist or a Physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.
- I recognize my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize 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 recommended by my physician to achieve increased function and improved quality of life.
- I agree I shall inform any doctor who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medication(s) prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. Any unauthorized increase in the dose of medication(s) may be viewed as cause for discontinuation of treatment.
- I must keep all follow-up appointments as recommended by my physician or my treatment may be discontinued. If I do need to cancel or reschedule an appointment, I will provide my physician with at least 24 hour notice. I also understand that any attendance non-compliance may require management approval and fee(s) paid before rescheduling.

I certify and agree to the following:

1. I am **not currently using illegal drugs or abusing prescription medication(s)** and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this Agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

2. I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, benzodiazepines, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

3. **No guarantee or assurance has been made** as to the results that may be obtained for chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize it provides me an opportunity to lead a more productive and active life.

4. I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of this medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

Patient Name: _____ **DOB:** _____ **Date:** _____

Patient Signature: _____ **Patient Pharmacy/Location:** _____

Physician Signature: _____ **Date:** _____