AWARENESS SHEET

POTENTIAL OPIATE SIDE EFFECTS/RISKS

You *MUST* be aware that opiates/narcotics have the potential for significant side effects which include:

1. Persistent constipation. This is likely to occur. Taking medications to prevent this problem are recommended and will be available through your prescribing doctor. Please avoid the intake of bulk-forming medications such as Metamucil.

2. Nausea and vomiting. If this complaint becomes consistent and appears on a regular basis, notify your doctor.

3. Excessive drowsiness and sedation. It is *VERY IMPORTANT* for you and your family to pay attention to this potential side effect. It may seriously affect your *CAPACITY TO DRIVE* or to operate dangerous machinery. *AT THE FIRST* sign of significant sedation, please stop driving or operating dangerous equipment, and performing potentially hazardous activities (swimming alone, etc.). There are medications to treat this side effect but they need to be discussed with your prescribing doctor before taking them.

4. Other potential side effects include pruritus (itching), decreased sexual performance, mood changes and insomnia.

5. Be aware that *ALL* opiates/narcotics have the potential to create **physical dependence and/or addiction.** Physical dependence means that once started on these medications your body may "get used" to them and if stopped abruptly they may provoke a withdrawal syndrome which is *NOT* life-threatening but can be quite uncomfortable (flu-like symptoms, abdominal cramps, diarrhea, anxiety, etc.) and may last for a few days. Addiction means the psychological "craving" for these drugs. Addiction is rare in individuals who are taking pain medication for medical reasons. It is more common in individuals who have a preexisting problem of addiction to drugs or alcohol. If you have a history of addiction you must inform your physician immediately.

6. Please take your medications the way they are prescribed. *DO NOT* change the schedule, break tablets in half or take extra doses, unless this is part of a pre- established plan. Failure to take your medication as prescribed may lead to **respiratory depression, cardiac arrest and death.**

Patient Signature _____

Print Name _____

Birth Date _____

Date _____

MEDICATION MANAGEMENT AGREEMENT

This Agreement between _____, ("Patient") and ("Doctor") is for the purpose of establishing agreement between Doctor and Patient on clear conditions for the prescription and use of pain controlling medications prescribed by the Doctor for the Patient. Doctor and Patient agree that this Agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship. The Patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Doctor for the Patient:

I understand that a reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program.

I realize that all medications have potential side effects.

I realize that it is my responsibility to keep myself and others from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity.

I will not attempt to get pain medication from any other health care provider. If my primary care physician is willing to prescribe my medications, the Doctor will make arrangements to transfer my care to my primary care physician.

I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my prescribed medication for a period of time.

I understand that it is my responsibility to schedule and keep a follow-up appointment with my doctor for all medication refills. Medications will not be refilled over the phone or on a walk-in basis. Refills will not be made if you run out early.

Refills will not be made on an emergency basis.

I agree that I will submit to a blood or urine test if requested by my Doctor to determine my compliance with my regimen of pain control medication.

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

Doctor and Patient agree that this Agreement is essential to the Doctor's ability to treat the Patient's pain effectively and that failure of the Patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Doctor and the termination of the Doctor/Patient relationship.

This agreement is entered into on this _____ day of _____ , 20____.

Patient Signature_____ Print Signature _____

Birth Date _____

Physician _____ Witness _____

RX POLICY

DO YOU HAVE ENOUGH MEDICATION UNTIL YOUR NEXT VISIT WITH YOUR PHYSICIAN?

It is extremely important that you make sure that you have enough of the medication that you are taking to last beyond your next scheduled visit with your physician. This ensures that you will have continuous access to your medication. For the sake of your good health care, please take a moment with your physician to ensure that you have enough medication.

The policy of physicians at Aspire PMC with respect to prescribing (or refilling) medications over the phone is:

1. *Non-narcotic medications which have been previously prescribed by a Aspire PMC physician will be considered for phone renewal if deemed appropriate.*

2. ***Narcotic medications will be refilled ONLY at the time of your appointment.***

3. *Make your next appointment for triplicate renewal at least one month from today with your doctor to ensure that you will have a visit scheduled in adequate time with Aspire PMC.*

Signed _____ Date _____

Print Signature _____

Birth Date _____

Witness _____ Date _____