

Northwest Spine & Sports Physicians, P.C.
Consent for Chronic Opioid Therapy

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Patient Name: _____ SSN: _____

I agree to the following:

1. I understand that I have a pain problem which currently requires the prescription of opioid (narcotic) pain medications designed to help me improve my ability to function.
2. It is in my best interest to have the opioid (narcotic) medications prescribed to me in a controlled environment to decrease the chance for development of psychological dependency or addiction.
3. I am currently not abusing prescription or non-prescription drugs, and I am not undergoing treatment of addiction or substance abuse.
4. I certify that I have disclosed to my physician any past diagnoses or treatments of psychiatric condition, drug or alcohol abuse.
5. I agree that while I am being treated with narcotic medication I will abstain from alcohol use. I understand the dangers involved in using alcohol while also taking narcotic medications.
6. I have never been involved in the sale, illegal possession or transport of controlled substances such as narcotics, sleeping pills or other pain pills.
7. I agree to obtain all prescriptions for narcotic medications or sleeping pills from Northwest Spine & Sports Physicians.
8. I agree to use only one pharmacy for filling of narcotic medications, and I will supply that pharmacy name and number to Northwest Spine & Sports Physicians.
9. I agree to allow my spine physician at Northwest Spine & Sports Physicians to communicate with referring physicians and pharmacists regarding my pain medications.
10. I agree to follow the treatment plan as outlined to me by my physician at Northwest Spine and Sports Physicians. This includes all visits to physical therapy, pain management specialists and other physicians, chiropractors and allied health professionals to whom I may be referred.
11. I agree to take my pain medications exactly as prescribed by my Northwest Spine & Sports Physicians physician.
12. I certify that I am not pregnant, and will stop taking narcotic medications if I become pregnant.
13. I agree to keep all scheduled appointments at Northwest Spine & Sports Physicians.
14. I agree to have a urine or blood test done randomly at my physician's request.
15. I understand that lost, stolen or misplaced prescriptions or medications will not be replaced.
16. I understand that NO refills will be made before their scheduled time or after normal office hours during the week, on holidays or the weekend. If I request a refill I must do so at least two business days before the medication is due.
17. If I deviate from the above guidelines or if the medication loses its effectiveness in increasing my function, I understand that it will be promptly tapered in a manner that will decrease the chance of any withdrawal side effects.
18. Medication may cause drowsiness; if you feel impaired, you should not operate a car or dangerous machinery.

Signature _____ Date _____