Michiana Spine, Sports & Occupational Rehab, P.C.
3740 Edison Lakes Parkway, Mishawaka, IN 46545 Toll Free (888) 734-2246 Fax (574) 252-4161
Kevin G. Drew, MD; John L. Kittredge, PA-C; Alessandra Chatson, FNP

MISSOR CHRONIC OPIOID CONTRACT

Patient Name: _____

Since other treatments have not controlled your pain, the doctors of Michiana Spine, Sports & Occupational Rehab P.C. (MISSOR) may decide to place you on a trial of opioids (narcotic pain medications). The goal is to manage your pain better and improve your social and work activities. This is a serious decision. This type of treatment does have risks, the most common of which are listed below. Please initial at the lines below.

RISKS:

1. Constipation, decreased appetite, nausea and vomiting.
2. Confusion or other change in mental state or mental thinking ability. Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles.
3. Increased sleepiness or drowsiness.
4. Breathing too slowly -- ***overdose or use of opioids with alcohol or sedatives such as Valium, Ativan, Xanax and others, can lead to respiratory arrest and death. We do not want you to take these drugs.***

____ Initial

5. Physical dependence – abrupt stopping of the drug may lead to a withdrawal syndrome characterized by one or more of the following: r**unny nose, diarrhea, abdominal cramping, goose flesh, anxiety and aches.**

6. Addiction or psychological dependence—stopping the drug may cause you to miss or crave it.
7. Tolerance – you need more and more drug to get the same effect.

8. Children born to mothers on controlled substances are usually physically dependent on the drug at birth.

___ Initial **ALERT MISSOR AT ONCE IF YOU ARE PREGNANT OR THERE IS A POSSIBILTY YOU MAY BE PREGNANT.**

9. Other less common risks and side effects are possible, including decreased testosterone and itching.

10. ***The long-term use of opioid therapy (narcotics) is controversial since we are not certain this treatment improves the quality of life of those who receive it. There is a potential risk of addiction developing or relapsing in those with previous addictions. These drugs have the risk of abuse and diversion and their use requires strict accountability. You must keep track of all your medication.***

We will begin or continue treating you with narcotics (opioids) under the following set of conditions.

1. I have not responded to other reasonable forms of treatment, or they have produced too many side effects.

2. I do not have problems with substance abuse or dependence.

3. I have never been involved in the sale, illegal possession, diversion, or transport of controlled substances (narcotics, sleeping pills, nerve pills, or painkillers), or deception to obtain these substances.

4. I will obtain **ALL** prescriptions for opioids (narcotic pain medications) from MISSOR only.
I WILL REFUSE TO ACCEPT OPIOIDS FROM ANYONE ELSE, INCLUDING OTHER PHYSICIANS.

5. I will inform MISSOR of all medications I take, including all controlled substances.

___ Initial **I will take medicines ONLY as prescribed by MISSOR and will never allow anyone else to take any of my medications. I will keep the medications locked and safe at all times.**

6. I will follow the advice of the physicians of MISSOR in regard to stopping controlled substances, if they tell me to do so. **I will not take old prescriptions.**

7. If a female of childbearing age, **I will certify that I am not pregnant and that I will use appropriate measures to prevent pregnancy during the course of treatment with opioids.**

8. I may be required to have unannounced random urine tests in order to properly assess the effect of the narcotics and my compliance. I may be required to have random unannounced alcohol testing.

9. **I may be asked to bring in my medications between visits for pill counts and I will cooperate fully.** ***Failure to show up with your pills at a pill count may result in termination from MISSOR.***

10. I will keep all scheduled appointments with MISSOR.

11. I will follow through on any referrals for psychological or substance abuse issues that MISSOR recommends.

12. ___ **I understand that NO allowance will be made for lost prescriptions of drugs. Prescriptions will NOT be refilled early under any circumstances.**

Initial

13. Refills must be done at an office visit. No medications will be called in, nor filled after hours.

14. I will use only one pharmacy for filling my prescriptions for opioids.

Name of Pharmacy City State Phone Number

15. Disposal of medications: For safety reasons, FDA recommends that a few, select medicines be disposed of by flushing down the sink or toilet. Accidental exposure to these medicines could harmful, and in some cases deadly in a single dose, if they are used by someone other than the person the medicine was prescribed for. Flushing these medicines down the sink or toilet completely removes this risk from the home. (From FDA website)

16. I understand that *opioid treatment will be stopped* if any of the following occur:

___ **If the MISSOR physician feels that opioids are not effective for my pain, or that my functional**
Initial **activity is not improved.**

a. **I give, sell, or misuse the drugs, including taking non-prescribed drugs or escalating doses of medications. I show any sign of not being in control of my medications.**
b. **I develop rapid tolerance or loss of effect from this treatment.**
c. **I develop side effects that are significant in the view of the MISSOR physicians.**
d. **I obtain opioids from sources other than MISSOR.**
e. **I fail to comply with other parts of recommended treatment (physical therapy, behavioral pain management, drug screens, and pill counts).**

If we choose to discontinue your opioids, we will generally lower the dose slowly over several days. If we feel that you have a dependency problem, we may choose to refer you elsewhere for management of the dependency.

MISSOR is hereby authorized to communicate with any pharmacy and other medical or legal professionals (at the discretion of MISSOR) regarding my use of controlled substances.

This authorization shall be in force and effect from and after its execution, until it is revoked. I understand that I have a right to revoke the Authorization at any time. I understand that if I revoke this Authorization, I must do so in writing and present my written revocation to MISSOR. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this Authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I have read this document, understand it, and have had all my questions answered satisfactorily. I agree to the use of opioids to help control my pain, I understand the risks associated with opioids and I understand that my treatment with opioids will be carried out in accordance with the conditions stated above.

Patient Signature: _____ Date: _____

Witness Signature:_____ Date:_____