Informed Consent Agreement for the Treatment of Chronic Pain with Narcotics

I have been diagnosed with _____. This diagnosis has been confirmed by _____.

The medication that I have been prescribed for the treatment of my condition is _____

I understand that there are alternative treatments which include _____.

The goal of my therapy is to reduce my pain to a level that is tolerable and will allow me to improve my day to day functioning.

I understand that daily use of a narcotic increases certain risks, which include but are not limited to:

- Addiction
- Nausea, vomiting and constipation
- Allergic reactions, overdose and fatal complications
- Breathing problems
- Dizziness
- Impaired ability to operate machines or drive motor vehicles
- Development of tolerance

I agree to the following guidelines:

1. I will take this medication as prescribed by my provider. I will not vary the dosage or interval without authorization from my provider.

2. I will submit to random blood or urine tests if requested by my provider to assess my compliance.

3. I will obtain all my prescriptions through Dr. _____ and will fill all my prescriptions at _____. In an acute emergency another provider may prescribe medications for me. If this occurs I will notify my primary care provider as soon as possible.

4. Due to the potential for misuse, I know that I will be unable to obtain early refills or replacement of lost or stolen medication. Refills will only be made during regular office hours.

5. I agree to see Dr. _____ for ongoing case management and will schedule regular appointments as long as I am taking this narcotic medication.

6. If I do not follow these guidelines I understand that my treatment may be terminated.

I have discussed the risks, benefits and alternatives to narcotic treatment with my provider. I have had an opportunity to ask questions and receive answers to those questions to my satisfaction.

_____	_____	_____
Patient Signature	Date	Provider signature
		Date