Alamance Regional Medical Center
1236 Huffman Mill Road
Burlington, NC 27215
Pain Management Centers
Opioid Informed Consent Form

Chronic Opioid/Opiate Medication Agreement Form

Purpose: to clearly establish the treatment boundaries for the prescription of opioids/opiates.

Directions: By signing my initials next to each statement, I am certifying that I have read it, that I clearly understand it, and that I agree to follow it.

_____ **Item 01:** I agree to have an active and current Primary Care Physician (**PCP**) (Family Doctor, General Practitioner, or Internist), at all times.

_____ **Item 02:** I agree to **fully cooperate**, participate, and answer any evaluations, questionnaires, tests, and consults that NCPMS may believe to be necessary for my care, and medication monitoring.

_____ **Item 03:** I agree to tell my doctor my complete and honest personal drug history and that of my family, to the best of my knowledge.

_____ **Item 04:** I agree to **tell my doctor about all other medicines** and treatments that I am receiving.

_____ **Item 05:** I agree to **always tell** my physicians **the truth**, all of the truth, and nothing but the truth, and **never to omit** anything when it comes to my current and past medical history, including all substances, legal and illegal, that I may be using, or may have used.

_____ **Item 06:** I agree to **allow NCPMS to conduct** criminal and medication background checks, as well as psychological and functional screening tests, for the purpose of assessing my case, my particular risks and my compliance.

_____ **Item 07:** I agree to **allow my physician to contact** and communicate with any of my prior and/or current healthcare professionals, family members, pharmacies, legal authorities, or regulatory agencies, to obtain or provide information about my care or actions.

_____ **Item 08:** I agree to **NCPMS'** medication monitoring program and its frequent, unannounced drug screening tests.

_____ **Item 09:** I agree to submit myself to random drug testing.

_____ **Item 10:** I agree to comply with **NCPMS'** "**Medication Policy**".

_____ **Item 11:** I agree to abide by the rules of this program.

_____ **Item 12:** I agree to notify **NCPMS** if I no longer want to continue with this type of therapy.

_____ **Item 13:** I agree **not to** call requesting medication refills over the phone.

_____ **Item 14:** I agree to request refills of my medications only during my regular appointment.

_____ **Item 15:** I agree **not to** request prescriptions or refills after normal business hours, nights, holidays, or weekends.

_____ **Item 16:** I agree to always bring my medications to the appointments.

_____ **Item 17:** I agree never to share, give, lend, or sell any of my medication to anyone.

_____ **Item 18:** I agree to always check with my pharmacist whenever I am given a new medication.

_____ **Item 19:** I agree to **keep** these medications **away from the reach of children** and other adults.

_____ **Item 20:** I agree to be responsible for the medication's **safe keeping, storage, and handling**.

_____ **Item 21:** I agree to notify my physician of any **side effects or adverse reactions** that I may be experiencing from the medications.

_____ **Item 22: (Females only)** I agree to notify NCPMS if I became **pregnant**, or are planning to become pregnant.

_____ **Item 23:** I agree to never be involved in any activity that may be dangerous to me or someone else, such as driving, operating heavy machinery, handling any weapons**,** working in a dangerous environment, or around unprotected heights, or being responsible for other individuals who are unable to care for themselves, **while under the influence and effects** of these type of medications.

_____ **Item 24:** I agree to notify my physician, if I suspect that I have become addicted to these medications.

_____ **Item 25:** I agree to undergo "**Drug Holidays**" when requested by my physician.

_____ **Item 26:** I agree never to combine these opioids/opiate medications with other substances, such as **alcohol** or alcohol containing medications (cough syrups), or illegal drugs/substances.

_____ **Item 27:** I agree to be responsible for always consulting my **pharmacist** about possible **drug-to-drug interactions**, when taking other medications such as antibiotics, dietary supplements, "Medical Food", and any other over-the-counter medications.

_____ **Item 28:** I agree to inform all of my healthcare providers that I am receiving opioid/opiate narcotics from **NCPMS**, and reminding them not to prescribe any medications that would contain similar drugs, or may interact with my medications.

_____ **Item 29:** I agree **never take more pain medicine than prescribed**.

_____ **Item 30:** I agree to **keep these medications under lock and key**, in a safe place, away from the reach of children and everyone else but me, even if I live alone.

_____ **Item 31:** I agree **never solicit or accept** any other **pain medication(s), from any other source(s)**, other than from this pain program.

_____ **Item 32:** I understand that signing this document does not mean than my pain physician is obligated in any way to prescribe or continue prescribing any of these medications to me.

_____ **Item 33:** I understand and agree to this document being self renewable, on a yearly basis.

_____ **Item 34:** I agree to responsible for keeping my family fully informed of the risks associated with this therapy and the fact that they will need to assist and participate in the responsibility of monitoring my use or misuse of these substances.

_____ **Item 35:** I agree not to get any more narcotics from any other practices, including during emergency room visits, once I begin to get opioid/opiate prescriptions from **NCPMS**.

_____ **Item 36:** I understand that by voluntarily signing below, I acknowledge the above information, accept the risks and responsibilities of this type of therapy, and I give **NC Pain Management Services, PA (NCPMS)** and its affiliate(s) my consent to treat me and my pain with opioids/opiates, and if necessary, to discontinue therapy.

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I hereby certify that I have read this form or have had it read to me, that I understand all of it, and that I have had a chance to have all of my questions answered to my satisfaction. By voluntarily signing this form, I agree and accept the responsibilities associated with this type of therapy. I also understand that failure to comply with the above regulations may result in the immediate discontinuation of the controlled substances been prescribed, as well as possible discharge from the program. I understand that this Agreement contains the entire agreement of the parties and supersedes and replaces all prior agreements between the parties and such other agreements shall be null and void and of no further force or effect. I also understand that this document is self renewable, on a yearly basis. I agree that should I decide to terminate this agreement, I will do so in writing. This agreement will go into effect when pain medications are prescribed by this program or its affiliates.

Patient's Name _____ Date of birth _____/_____/____

_____	_____	_____
Patient's Signature	Date	Time