Andreas J. Edrich MD FASAM MRO
Family Medicine - Board Certified
Addiction Medicine- Board Certified
Medical Review Officer-Certified

Nicci Kochsmeier PA-C
Christine O'Neal PA-C
Jillian Just PA-C

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Controlled substances agreement

CONSENT FORM FOR THE USE OF OPIOID and BENZO MEDICATIONS

I, (above printed) on DATE__________, have been informed and clearly understand the following issues regarding the treatment of pain with opioids (i.e., morphine and or morphine-like drugs like percocet, vicodin, oxycodone, oxyontin and others and or the treatment with benzodiazepines (like valium, xanax, klonopin, diazepam, alprazolam, clonazepam)

1. INITIAL _______**monthly visits are required** for management of these medications and refills of the medication prescribed will be given on a monthly basis. Failure to perform monthly visits would result in slow tapering and ultimate discontinuation of medications and possible discharge from our practice

2. **INITIAL _______Medications will ONLY be prescribed by OUR practice (HHFM) and NO outside provider** You must be aware that "doctor shopping" is an unacceptable behavior. You hereby agree that you will limit any prescriptions for any and all opioids/benzos to the providers at HHFM. Only our providers will determine the dose of your medication and you understand that you may not under any circumstances adjust your own dose. If we at HHFM decide to discontinue the use of controlled meds, the we will follow you through the tapering off period and the YOU the patient will agree to recommendations made by the us.

3. INITIAL _______The use of the medication **may not completely eliminate your symptoms (pain, anxiety etc)** . Rather, the medication is used to help reduce symptoms so that the you will be able to perform your activities of daily living. It is hoped that the use of these medications will improve the quality of life but it is NOT expected that symptom relief will be complete.

4. INITIAL _______YOU, the patient **must report significant side effects** from your medication/s. For example: over-sedation, nausea, vomiting, constipation, confusion, euphoria (high feelings), and dysphoria (down feelings). Other side effects which may be related to medication use also include dizziness, sweating, respiratory depression, stomach upset, quick-sudden jerky movements of arms or legs, headaches, weakness, tremor,

seizure, dreams, musculature rigidity, transient hallucinations, disorientation, visual disturbances, insomnia, dry mouth, diarrhea, stomach cramps, taste alteration, flushing of the face, chills, increased or decreased heart rate, increased or decreased blood pressure, difficulty with urination, itching, skin rashes, and swelling of the skin.

5. INITIAL _______YOU clearly understand that the use of **the medication may result in physical dependence**. This condition is common to these meds and can occur in less than a month. You understand that dependency is a condition that sometimes is needed to achieve the control that can provide you quality of life but that it can be very difficult to wean off these meds. You must understand that dependence is NOT the same as addiction.

6. INITIAL _______You understand that **developing addiction is also possible by using these medications.** Addiction is when patients take medications outside of the prescription or begin to find extra medications from other doctors or other sources or use these meds to gain a high or relief ("the pathologic pursuit of reward or relief"). You must immediately make us aware if YOU, the patient start to use the medication differently from how we prescribed it, if you feel mental numbness or euphoria, if you experience drug cravings for the drug, if it seems like the drug is wearing off. If this happens we may need to taper the medications. If there is any failure to follow medication monitoring procedures we may discharge you from our practice.

7. **INITIAL _______Tolerance is also a condition which can occur with the use of these medications.** This is defined as a need for higher doses to maintain the same control. We will attempt to avoid tolerance by using other medications in conjunction with your opioid or benzo medication. If tolerance to these meds becomes unmanageable, the medication will be discontinued.
8. INITIAL _______**YOU may not drive motor vehicles or operate machinery if you develop any drowsiness, sedation, dizziness or any other symptoms that would prevent you from acting safe.** If you DO, you may hurt or kill yourself or others. YOU the patient are responsible for **contacting the physician if at any time excessive drowsiness** or other major side effects develop. The phone number to contact is **303-792-3333**.
9. INITIAL _______Use of this medication is **only designed for the individual on the prescription bottle.** You will never give your medications to others. Failure to comply will lead to discharge from our practice.

10. INITIAL _______YOU the patient are informed that you should **not stop taking the medications abruptly. If you feel you wish to stop these medications you MUST call us the SAME day even weekends/holidays but do not self adjust.** If this happens, withdrawal symptoms may occur 24-48 hours after the last dose. You may begin to experience yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot or cold flashes, "goose flesh," abdominal cramps and diarrhea. The withdrawal symptoms are self-limited but could be life-threatening. Withdrawal symptoms may last from days to weeks. YOU must plan accordingly for your refills and allow at least 4-7days.

11. INITIAL _______YOU the patient are informed that you may **not take other medications such as tranquilizers, sedatives or antihistamines, antipsychotics without first consulting with us at HHFM. You may not use alcohol EVER under any circumstance.** The combination of the opioid medications, alcohol and tranquilizers may produce profound sedation, respiratory depression and blood pressure drop and can cause death.
12. INITIAL _______While you are on these medications **you MUST follow the our directions and not change your dosage on your own**. Drug overdose can cause severe sedation and respiratory depression and death. Adjusting your own medication may result in discharge from our practice.
13. **INITIAL _______The medications should be taken as prescribed.** Medications should be taken whole and are not to be broken (unless specifically noted on the prescription), chewed, or crushed. Possible risk of doing this may include death.
14. INITIAL _______**All female patients should notify the physician if they are pregnant or possibly at risk to become pregnant.** It should be known that children born when the mother is on these medications will likely be physically dependent at birth. You MUST call us immediately (the same day 24/7/365) when pregnancy is discovered. You MUST NOT adjust your medication dose on your own under any circumstances. This may produce withdrawals in your baby and may cause miscarriage. Call us immediately day or night and we will help manage the proper course for you.
15. INITIAL _______If there is **any evidence of drug hoarding, acquisition of drugs from other physicians**, uncontrolled dose escalation or other aberrant behavior, you may be discharged from our practice.
16. INITIAL _______I HEREBY ATTEST THAT THIS FORM WAS READ TO ME IN FULL AND THAT I AM COHERENT AND ABLE TO UNDERSTAND WRITTEN AND SPOKEN ENGLISH

SIGNATURE OF PATIENT:____DATE: __________

READ to pt by: ____DATE: __________

SIGNATURE OF ADD'L:____DATE: __________

SIGNATURE OF
PHYSICIAN:____DATE:__________