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**LONG TERM OPIOID THERAPY FOR THE TREATMENT OF NON-CANCER PAIN**
**INFORMED CONSENT/AGREEMENT FORM**

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This is an agreement between _____ (the patient) and Julie Huang-Lionnet, MD (the physician) concerning the use of opioid analgesics for the treatment of my chronic pain problem. The medication will probably not completely eliminate my pain, but is expected to reduce it enough that I may become more functional and improve my quality of life. The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management and the conditions under which you will be expected to comply with. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals and is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

This agreement is a "one strike and out" agreement. Any subsequent violation of this agreement, FOR ANY REASON, will result in termination of opioid therapy. If the doctor feels there have been any violations of Federal, State, or Local laws, then these violations may be reported to law enforcement officials. You agree to hold Greenwich Health, PLLC harmless from any adverse outcome from this action.

1. I understand that opioid analgesics are strong medications for pain relief and I. have been informed of the risks and side effects involved with taking them.
2. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting diarrhea, aches, sweating, chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable but not a life- threatening condition.
3. I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids, and withdrawal can be life- threatening for a baby.
4. To the best of my knowledge, I am not pregnant at this time. I understand these medications are considered dangerous to a fetus. I will do everything possible to avoid getting pregnant while taking these medications unless otherwise approved by my doctor.
5. We encourage you to do your best to avoid pregnancy while on opioids. There are risks to unborn children, including, but not limited to birth defects, addiction, tolerance, and the suffering or withdrawal resulting in the need for costly and prolonged hospitalization. Women of childbearing age will undergo pregnancy screening prior to initiation of therapy and at each regularly scheduled refill visit. Should you become pregnant, opioid medications may be tapered and stopped.
6. Overdose on this medication may cause death by stopping my breathing; this can be reversed by emergency medical personnel if they know I have taken narcotic pain-killers. It is suggested that I wear a medical alert bracelet or necklace that contains this information.
7. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.
8. I understand it is my responsibility to inform the doctor of any and all side effects I have from this medication.
9. I agree to take this medication as prescribed, and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. Running out early, needing early refills, escalating doses without permission, and losing prescriptions may be signs of misuse of the medication, and may be reasons for the doctor to discontinue prescribing to me.
10. I will not increase or change medications without the approval of this doctor. Any changes to my prescription must be discussed with my physician prior to changing. I will not share or sell my prescription, and will bring unused pain medication to each subsequent visit.
11. I agree that the opioids will be prescribed by only one doctor, and I agree to fill my prescriptions at only one designated pharmacy. I agree not to take any pain medication or mind-altering medication prescribed by any other physician without first discussing it with the above-named doctor.
12. I give permission for the doctor to verify that I am not seeing other doctors for opioid medication or going to other pharmacies.
13. I agree to the Connecticut and/or New York Prescription Monitoring Program (PMP) upon signing this agreement, and regular, random occasions thereafter, which will be used by Greenwich Health, PLLC to measure my compliance with this agreement. I will allow my doctor to receive information from any health care provider or pharmacist about the use or possible misuse/abuse of opioids, alcohol and other drugs. I will submit a urine or blood specimen upon initiation of this agreement, and at random, regular intervals to measure compliance with this agreement.
14. I agree that my opioid medication will be continued as long as there is demonstrated improvement in my pain level and function as determined by the prescribing physician (going to work, school, etc.). I understand that my doctor will gradually take me off of my opioid medication if I do not follow the above plan, or if my doctor believes the opioids are not helping or are harming me. I expressly agree to hold Greenwich Health, PLLC harmless to, any real or imagined consequence from discontinuation.
15. Flare-ups or exacerbation of pain will occur from time to time and will be handled by therapies such as ice, heat, TENS, or relaxation rather than additional medications.
16. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced. I agree not to sell, lend, or in any way give my medication to any other person.
17. If I lose or misplace my prescription, I must report this to the police department and provide us with a copy of their report before a substitute prescription can be provided. If an emergency requiring opioid treatment occurs (an Emergency Room visit for example), I will contact this office the next working day and inform us of the circumstances.
18. I will not attempt to obtain and/or use any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor or person. This includes addictive medications such as sleeping pills (Ambien, Lunesta), tranquilizers (Valium, Xanax, etc.), or stimulants (Ritalin, etc.) from other physicians without authorization from the Pain Clinic.
19. I agree not to drink alcohol or take mood altering drugs while I am taking opioid analgesic medication.
20. I will not use any illegal controlled substances, including marijuana, cocaine, etc.
21. I agree to submit a urine specimen at any time that my doctor requests, and give my permission for it to be tested for alcohol and drugs to determine my compliance with my program of pain control medicine.

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22. I agree that I will attend all required follow-up visits with the doctor to monitor this medication. I will bring all unused pain medicine to every office visit, and I understand that failure to do so will result in discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities recommended by my doctor.
23. I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends. Walk-in visits for medication refills are not allowed. Our office will not provide early refills, and will NOT phone in prescriptions for controlled substances under any circumstances.
24. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.
25. I agree to be seen by any specialist including a psychiatrist or addictionologist at the discretion of the prescribing doctor. I will submit to any standardized psychological assessments required by prescribing physician, including those administered at Greenwich Health.
26. I understand that if I break this Agreement, my doctor will stop prescribing these pain control medicines. In this case, my doctor may choose to taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. If this is not deemed to be viable option, I will be provided with a 30 (thirty) day supply of my medications to maintain while my care is transferred to a new physician. Also, a drug-dependence treatment program may be recommended. All information regarding my care will be transferred to my new treating physician upon request.
27. I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
28. I agree to hold Greenwich Health, PLLC. and my prescribing doctor totally and completely harmless from any claim arising out of use of these controlled substances including any event attributed to overdose, side effect, development of tolerance, dependence, addiction, failure to take the medication as ordered, or dissatisfaction with the level of pain control the medications afford me
29. If opioid therapy is terminated, I will be provided with a de-escalating dose plan and I will be responsible to follow it. Failure to follow the de-escalating plan may result in experiencing intense, unpleasant physical withdrawal. Should this happen I expressly agree to hold the prescribing physician and Greenwich Health, PLLC harmless from this experience.
30. If opioid therapy is terminated, this does not necessarily mean I will not be able to return to Greenwich Health, PLLC for on-narcotic procedures, therapies, or medication management. It just means that my trial of opioids is considered a failure. However, if further treatment is determined to be unacceptable by either party, I will be provided the phone number to the Fairfield County Medical Association, which maintains a list of other pain management doctors in my area, in accordance with the relevant provisions of Connecticut and Federal law, including the provisions of the Medicare Conditions of Participation for Hospitals addressing patients' rights, 42 Code of Federal Regulations Statute 482.13. I will then be considered discharged from the practice and the treatment considered complete, and I expressly agree this cannot be construed as abandonment.

**CONSENT TO AGREEMENT**

I have read the above and understand the agreement. All of my questions and concerns regarding treatment have been adequately answered. I agree to follow these guidelines that have been fully explained to me. If I violate the agreement, I know that the doctor may discontinue this form of treatment. A copy of this document has been given to me.

This consent has been read and understood by me, and I agree to all of the above.

| _____ | _____ | _____ |
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| Signature of Patient or Responsible Party | Print Name | Date |
| _____ | _____ | _____ |
| Signature of Witness | Print Name | Date |
| _____ | _____ | _____ |
| Physician Signature | Print Name | Date |

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