NEWPORT ORTHOPEDIC INSTITUTE

Pain Management Policies/ Opioid Agreement

Purpose of Agreement:
This agreement is designed to give you exemplary care while being supervised by an NOI pain management physician. We encourage you to get involved in your health care. NOI will utilize your advocacy and our resources, to give you the best care possible.

What is an Opioid?
Opioid is a class of drugs that include the illegal drug heroin, synthetic opioids such as Fentanyl, and pain relievers (narcotics) that are available by a prescription.

Patient Agreement: please initial each line after you have read and understood the agreement

____ I will be active and engaged in my medical care.
____ I will bring a list of all of my current medications to each visit.
____ I will only get opioid medication from Dr. _____.
____ I am aware that there is a risk of addiction to opioids. My physician/ physician assistant have explained the risks and benefits of taking opioids for my condition.
____ I have told my physician the honest, complete history of my opioid past and what I know of my family's past use of opioids.
____ I understand that it is required that I call in for a refill with 48 business hours notice. I also understand that there will be no refills given on Friday after 12 pm, all day Saturdays, or all day Sundays. Refills are processed Monday – Thursday from 8:00am to 4:00pm and Friday 8:00am – 12:00pm.
____ I will not take any opioid medication from another physician.
____ I will take my opioids as prescribed. I will not increase my medications on my own for mood changes, or for other pain problems; but I will use my self care skills.
____ Early refills will not be given out. If you are requesting an early refill, you will need to have an in office evaluation.
____ I realize that it is my responsibility to keep myself and others safe. I agree that if there is any question of impairment, I will not perform any activity that cannot be done safely or correctly while under the influence of my opioids (ie: driving).
____ I will not use any illegal drugs, calming medicines (sedatives), or alcohol. Combining any of the listed with opioid medications can be dangerous and have adverse side effects.
____ I will not share, sell, or trade my opioids with anyone. This is a violation of federal law.
____ I will keep my opioids in a safe place. I will keep my opioids out of the reach of children/ pets and will store them in a manner that prevents theft. Lost and/or destroyed medication will not be replaced. A police report will be required for all stolen or lost medications.
____ I know that my physician and pharmacy must comply with any and all state and federal laws for opioid management. (You can find more information at https://www.fda.gov/)
____ I allow my physician to provide a copy of this agreement to my pharmacy.
My pharmacy: _____
____ I will only use the pharmacy listed above

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____ My doctor may taper me off of my opioids if I fail to show up for my refill appointment or habitually reschedule. Two or more cancellations/ reschedule requests with less than one business days notice will jeopardize my relationship with my physician and the practice.
____ I understand that if I fail to follow my physician's instructions that may be a sign that my opioid medication is no longer a safe and effective way to manage my pain.
____ I understand that taking more than the amount prescribed or taking other opioids can cause symptoms of overdose. I will call 911 or contact my local poison control if I think I am having symptoms of an overdose. (Shallow breathing, confusion, lessened alertness, loss of consciousness)
____ I give consent for my physician to run status reports from the DEA and my insurance in order to ensure that I am abiding by this agreement.
____ I agree to cooperate with random drug testing whether urine, blood, or saliva.
____ I will go to physical therapy when told to do so
____ I will go to counseling (ie: drug rehab, alcohol counseling, family counseling, etc.) when told to do so
____ I will follow all directions for treatment requests from my physician/ physician assistant.
____ I will get past health records from other offices when prompted to do so
____ Failure to meet functional treatment goals or refusal to wean down on medications after goals have been met is considered a form of non compliance and may lead to or jeopardize my relationship with my physician and the practice.
____ Using your prescription pain medication for anything other than what it was prescribed for, is a sign of non compliance and can potentially terminate your agreement.
____ WOMEN ONLY: I will notify my physician immediately if I am planning on or become pregnant while under my opioid agreement. I am aware that if I give birth while on opioids, my baby may be dependent on my medication and have adverse affects.

This agreement will be in effect as long as the named physician is prescribing my opioid medication. If I continue to get refills on my opioid medication, that will serve as a monthly acceptance of this agreement.

I have read or have had read to me, the above agreement. I have had time to have any questions answered. I have no further questions. I understand that my failure to abide by any part of the agreement will result in discontinuation of opioids.

_____
Patient Printed Name

_____ _____
Signature of Patient Date

_____
Witness