HealthCare Pain Centers, LLC

- 314 Perrine Rd Suite 314, Old Bridge, NJ 08857
- ☐ 205 May St. Suite 202, Edison, NJ 08837
- ☐ 501 Iron Bridge Road, Suite 5, Freehold, NJ 07728

OPIOID CONSENT FORM
Informed Consent

Patient's Name:_____

This agreement relates to my use of opioids for chronic pain prescribed by HealthCare Pain Centers, LLC.

RISKS

I understand that these medications have potential risks, the most significant being:

1. Physical dependence: Abrupt stopping of the drug will lead to withdrawal syndrome characterized by abdominal cramping, diarrhea, "goose flesh" and anxiety.
2. Addiction or psychological dependence
3. Overdose can lead to respiratory arrest and death.
4. Mental changes such as confusion, changes in thinking abilities and problems with coordination and balance. I will use caution in operating equipment or motor vehicles.
5. Sexual difficulties; problems with urination.
6. Depression
7. Constipation; nausea

CONDITIONS OF CONSENT FORM

I understand I must comply with the following rules in order to receive care for the management of my pain condition at HCPR.

1. I will take the medications at the dose and frequency prescribed by HCPC. I will not receive medications from any other source.
2. I will not take more medication than instructed nor will I allow other individuals to take my medications. No changes will be made without notifying HCPC physicians.
3. I will let my primary physician know that I am on contract with HCPC for the prescription of controlled pain medications.
4. Changes in my prescription will only be made during scheduled office visits. No changes will be made over the phone or during unscheduled visits. New medications will not be prescribed over the phone.
5. I understand it is the policy not to replace damaged, lost or stolen medication. It is my responsibility to keep my medications in a secure place.
6. State law allows no more than 30-day supply or 100 tablets whichever is less, of medications to be given in a single prescription. I will not receive additional medication prior to the time of my next scheduled refill.

7. I will come to schedule appointments prepared to submit urine and blood samples to assess the effect of opioids and my compliance to treatment plan.
8. I do not currently have problems with substance abuse (drugs and/or alcohol).
9. I am not involved in the use, sale, possession, diversion, or transport of illegally obtained controlled substances (narcotics and/or illegal drugs).
10. I will notify HCPC if I am or become pregnant in the future due to the potential risks of narcotic addiction to the unborn child.
11. I understand that my chronic pain represents a complex problem that benefits from physical therapy, psychotherapy, and behavioral medicine strategies. I recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of pain Management Program to improve my level of functioning and my ability to cope with pain. If recommended, I agree to see other health care providers for evaluation and treatment of related and other medical conditions.
12. I will only use the following pharmacy. I will notify HCPC if I am to use a different pharmacy as above. I authorize HCPC to obtain a list of all the medications I am taking from my pharmacy.

Name of Pharmacy, Address and telephone number:

_____

_____

Any violation of this consent form will result in discontinuation of treatment with opioid medication.

I have read this document, understand it and have had all questions answered satisfactorily. I agree to all conditions of this opioid consent form. I have been provided a copy of this contract for me to keep.

_____

Patient's Signature **Date**

_____

Physician's Signature **Date**

_____

Family Member/Significant Other/Interpreter Signature **Date**

_____ **Renewal Date*** (*this contract will be renewed every year as needed)

_____ Copy given to patient