

Department of Medicine
Internal Medicine Suite
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Los Angeles, CA 90095
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Consent for Chronic Opioid Therapy

Dr. _____ is prescribing opioid medication, sometimes called narcotic analgesics, to me for a diagnosis of _____ .

This decision was made because my condition is serious or other treatments have not helped my pain.

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed include:

I will tell my doctor about all other medicines and treatments that I am receiving.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, or feeling the need to use a drug. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable and can even be life-threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

(Males only) I am aware that chronic opioid use has been associated with low testosterone level in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal. I am also aware that chronic opioid therapy may cause osteoporosis.

(Females only) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to deliver while taking these medicines, the baby will be physically dependent on opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid. I am also aware that chronic opioid therapy can cause osteoporosis.

I have read this form or have had it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medications.

Patient Signature

Patient Name (Printed)

Date

Witness