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LAS VEGAS UROLOGY

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Opioid (Narcotic) Consent Form and Management Agreement

This consent and agreement for treatment between the undersigned patient and prescribers at Las Vegas Urology, is to establish clear conditions and consent for the prescription and of use of pain controlling opioid medications or other controlled substances prescribed by the healthcare provider for the patient.

These medications are being prescribed only for treating pain. Along with medications, other medical care may be prescribed to improve the ability to do daily activities. This may include exercise, use of non-opioid analgesics (i.e. acetaminophen, ibuprofen, etc.), physical therapy, psychological evaluation/counseling, weight management, classes on managing pain, or other beneficial therapies for treatment.

The Patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Physician/Physician Assistant for the patient. Failure to comply with the conditions in this agreement may result in the medication being discontinued and possible terminating of the prescriber/patient relationship.

I understand that a reduction in the intensity of my pain AND improvement in my daily life functions are the goals of this program. Should it become evident that these goals are not being met with the use of pain medications, I understand the medications may be weaned and or discontinued.

1. I must comply with the following guidelines:
    a. I will take the prescribed medication at the dose and frequency prescribed.
    b. EARLY refills may not be given.
    c. I will not attempt to get pain medication from any other healthcare provider.
    d. I will obtain all medications from one pharmacy.
    e. I will consent to random drug screening at the provider's request. Unexpected results may result in changing or discontinuing my medications.
    f. I agree to bring my pain medication into the office to be counted if requested.

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g. I will not share, trade or sell my medication for money, goods, or services. I understand that these are prosecutable offenses and may be reported to the authorities.

h. If my medications are lost or stolen a re-evaluation of my competence to continue these medications may be performed.

i. I am required to keep my physician up to date on all medications that I am taking.

j. I have been advised on the proper use, storage, and disposal of the narcotic medication

2. I understand refills of my prescriptions should be addressed in person at scheduled office visits. I will not stop by the office without an appointment and I understand I will not be seen and refills will not be addressed without an appointment. Refills may not be made nights, weekends, or holidays.

3. I understand that the long-term effects of opioid therapy have yet to scientifically be determined and treatment may change throughout my time as a patient. I understand, accept, and agree that there may be unknown risks associated with the long-term use of opioids and my doctor will advise me as knowledge and training advance and will make appropriate treatment changes.

    a. In women of child-bearing age, I understand that opiate medications can have multiple short and long-term effects on a fetus including, but not limited to, neonatal withdrawal syndrome and various birth defects.

    b. I understand that all medications have potential side effects. For narcotic pain medications, these include but are not limited to: addiction, physical dependence, chemical dependence, constipation which may be severe enough to require medical treatment, difficult with urination, drowsiness, cognitive

    c. impairment, nausea, itching, depressed respiration, reduced sexual function and adverse effects or injury to the organs, as well as OVERDOSE and DEATH. A distinct clinical syndrome, “hyperalgesia syndrome”, has been described in the literature and can result in increased pain from continual and escalated doses of opioid medication.

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4. I understand that opioid antagonists (antidotes) are available at pharmacies in Nevada without a prescription. These include medications such as naloxone (Narcan®) nasal spray.

I have read the above and have had all my questions answered. I know that pain can be managed with many types of treatments. I understand that I am receiving this drug for short term pain relief and consent to receive the drug and understand the possible risk of tolerance and/or dependency with the prolonged use of this drug. I consent to the treatment and agree to use the medication as prescribed by my physician.

Patient Signature _____ Date _____

Print Patient Name _____ Date of Birth _____

Witness (receipt of copy of agreement): _____