Desert Valley Advanced Pain Management
11024 N 28th Drive Suite 160
Phoenix, AZ 85029

CONTRACT FOR CHRONIC OPIOID ADMINISTRATION

Print Name _____ Date _____

I am receiving Chronic Opioid Administration to treat the following medical condition: _____
_____
_____

I am using narcotic pain medication because other treatments and medication I have received have not controlled my pain. It is unlikely that any medication will completely take away my pain, but for humane reasons narcotic pain medication will be given to me provided that I follow the terms of this agreement.

I understand that there are risks associated with Chronic Opioid Administration such as dependence, addiction, change in personality, sleep change, bowel changed (such as constipation and even bowel obstruction), bladder changed, difficulty with urination, changes in appetite with possible weight gain or loss, sedation, change in coordination (which may interfere with driving, operating machinery and fine motor movement), sexual desire and performance, respiratory, death and others.

Sudden stopping of Chronic Opioid Administration can lead to rebound pain, withdrawal symptoms, seizures and other symptoms, I have been informed not to stop Chronic Opioid Administration suddenly unless decided jointly by myself and by you, my physician.

Medications interactions can increase the risks from Chronic Opioid Administration. I agree to inform you of any changed in my medications prescribed by physicians or medications used for self-treatment. I understand that alcohol use can significantly increase the risk from Chronic Opioid Administration. I agree to inform you of my alcohol practices so that we can discuss the risks of alcohol use and the interaction with Chronic Opioid Administration and the increased risk. All opiates can and do cause varying degree of respiratory depression. This lead to shortness of breath (especially in smokers and people with lung disease) and even death. I agree to inform you of my smoking practices so that we can discuss the risk of smoking and the smoking interactions with Chronic Opioid Administration and the increased risks.

To minimize risks, and to insure adequate supervision, I agree to come in for regular visits (every one or two months minimum). I agree not to mix alcohol with chronic opioid use and agree to report my changes in mental state and any adverse reactions. I agree to have lab tests you advise, including blood test, blood levels of medications, urine drug screen, pregnancy test, blood gas determination and others deemed as necessary. **I agree to obtain opiates from only one pharmacy and will inform you of any change in pharmacy. Narcotic refills will be provided during office visits only.**

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I understand that I must allow four (4) days for all medication prescription refill requests. Further more, I understand that failing to contact the office in a timely manner may result in the office's inability to accommodate my prescription needs. Medication prescriptions will not be handled over the weekend or on holidays.

I understand that if my opioid medication should be lost, stolen, destroyed, ect. Or used up early, you will not refill it until time for the next regular refill, no matter what the circumstances is. I agree to provide or assist in obtaining medical records for the last three years and earlier if deemed necessary.

I agree to have information release to the Arizona Board of Osteopathic Examiners in Medicine and Surgery, Board of medical Examiners, and Board of Pharmacy as deemed necessary by my physician as a precaution regarding any questions concerning the appropriateness of this medication and dose for my condition.

Noncompliance in the above will result in formal discharge with notification to my primary care physician and other physicians as deemed necessary.

_____ _____
Patients Signature Date

_____ _____
Physician Signature Date

_____ _____
Witness Date