



Treatment Plan Using Prescription Opioids

I _____ (Please print name) understand and agree to the following:

Initial each

_____ I understand that there are risks associated with using opiate medications. Serious risks may include respiratory depression, low blood pressure, cardiac arrest and shock, which may lead to death even when taking the medications as prescribed. Other risks may include constipation, nausea, vomiting, drowsiness, dizziness, itching, dry mouth, headache, fatigue, rash, hormone suppression and birth defects.

_____ I understand that using opiate medications may cause cognitive impairment that would make it unsafe to drive or operate machinery.

_____ I understand that taking opiate medications may lead to addiction. This is described as compulsive use for non-medical purposes despite harm or risk of harm. If addiction develops, it is likely that the opiate medications will be discontinued and treatment for the addiction will be implemented.

_____ Opioid (pain) medication has been prescribed to me to help manage my chronic pain and improve my function. If my activity level and/or function do not improve the medication may be discontinued.

Goal(s) for improved function (Example: work full time, yard work, house work, hiking, etc.)

_____ I agree to take the medication **exactly as prescribed** and will **NOT** change the dose without approval from the doctor. I understand that the doctor will **NOT** provide additional medications if I run out ahead of schedule.

_____ All opioid and controlled drugs for pain must only be prescribed by Eastern Utah Spine and Pain.

_____ If I have **another condition** that requires the prescription of a controlled drug (like narcotics, tranquilizers, barbiturates, or stimulants); or if I am **hospitalized** for any reason, I will inform the clinic within **ONE** business day.

_____ Lost, damaged, or stolen medication will **NOT** be replaced.

_____ I agree **NOT** to share, sell, or in any way provide medication to any other person.

_____ I authorize Eastern Utah Spine and Pain to share results of my drug screen and decisions regarding opiate treatment with other treating physicians including, but not limited to Castleview Hospital Emergency Department.

_____ I agree to refrain from the use of **ALL** other mood-modifying drugs, including alcohol and THC, unless agreed to by my prescriber. The moderate use of nicotine and caffeine are an exception.

_____ I agree to submit to random urine, blood, saliva testing, or pill count at Eastern Utah Spine and Pain's request, to verify compliance.

_____ I authorize Eastern Utah Spine and Pain and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency in the investigation of possible misuse, prescription forgery, sale or other diversion of my pain medications. I understand that illegal substance use may be reported to the proper authorities. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these organizations.

_____ I agree to obtain prescription medication from one designated pharmacy. I understand that Eastern Utah Spine and Pain may check the Utah controlled substance database at any time to check my compliance.

Pharmacy _____

- **Medication refill will only be given during regular business hours which are Monday through Thursdays 7-4 with lunch from 12-1, closed Fridays.**
- **At least a 3-day advance notice is required for medication refills**

I have read, understand, and will comply with this agreement. I have been given the opportunity to have my questions addressed regarding the above statements.

I understand that any deviation from the above agreement may be grounds for the prescriber to stop prescribing opioid therapy at any time.

Patients Signature _____ Physicians Signature _____ Date _____