

***Informed Consent and Risks/Benefits Notice for Treatment
of Chronic, Non-Malignant Pain with Controlled Substances***

Dear: _____,

Your doctor may diagnose you as having a condition that causes you pain. Your doctor may recommend that you treat your painful condition with opioids to reduce your pain and improve your function.

Your doctor wants you to know that there are alternatives to the proposed medication therapy, including physical therapy, chiropractic therapy, acupuncture, psychotherapy, percutaneous neuromodulation therapy, and interventional modalities (such as epidural steroid injections, etc.). There are also other types of medications such as NSIADS, Cox 2 inhibitors, muscle relaxants, antidepressants, anti-seizure medications, and certain blood pressure medications.

Your doctor wants you to know that as with the use of any medication, there are potential side effects and risks associated with the use of the above-named controlled substances, including:

- sleepiness, confusion, difficulty thinking
- nausea, vomiting, constipation
- difficulty breathing, shortness of breath, wheezing
- rash, itching
- potential for allergic reaction
- potential for interaction with other medications (increasing effects or side effects of drugs taken together)
- potential for dose escalation/tolerance (need for higher doses for the same effect may occur with long term use)
- potential for dependence (after the body adjusts to these medications, they cannot be stopped abruptly without causing physical symptoms)
- potential for withdrawal (stopping medications abruptly may cause nausea, vomiting, abdominal pain, sweating, aching, abnormal heartbeat or other symptoms that can be life threatening; medication changes should be under provider supervision)
- potential for addiction (compulsive drug use not related to pain relief)
- potential for impaired judgment and/or motor skills (driving or operating machinery may be hazardous due to effects on the brain and nerves)
- potential overdose from fentanyl patch if they are used in a Jacuzzi or other warm environment
- other:

This document confirms that your doctor will ask you if you want a more detailed explanation of the proposed treatment, the alternatives to the proposed treatment, **and the side effects and material risks associated with the proposed treatment, and you (check one):**

____. **Are satisfied with that explanation and desire no further information.**

____. **Requested and received, in substantial detail, further explanation of the proposed treatment, alternative forms of treatment, and side effects and material risks.**

If this form accurately represents your doctor's discussion with you, and if you are satisfied with the explanation given, you must sign this document indicating your consent to the use of controlled substances in treating your intractable pain prior to commencing the treatment.

Signed: _____

Date: _____

Rvsd 04/02/08