EKO INTERNAL MEDICINE

ARNOLD EKO-ISENALUMHE, M.D.

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PHONE: (931) 967-0360
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Pain Management Agreement

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

I understand that if I break this Agreement, my doctor will stop prescribing these pain-control medicines.

In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell or trade my medication with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or antianxiety medicines from any other doctor.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.

I agree that refills of my prescriptions for pain medicines will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

I agree to use _____ Pharmacy,

Located at _____,

telephone number _____, for filling prescriptions for all of my pain medicine.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unused pain medicine to every office visit.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this _____ day of

_____, _____.

Patient signature: _____

Physician signature: _____

Witnessed by: _____

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Informed Consent for Use of Opioid Pain Medication / Controlled Substances

Name: _____

Dr. _____ is prescribing Opioid medicine (Narcotics) to you for _____

_____ because other treatments have not helped your pain.

Indication for Use:
Not all pain responds to opioids. Being completely pain-free may not be possible. Some pain may only partially respond to opioids. Medications are only part of the solution and will not solve all of your pain. Exercising on a regular basis and using other pain management self-care techniques are equally or even more important.

You may need to stop opioid medication under these circumstances:

- Not getting enough pain relief
- No improvement in function
- Persistent side effects
- Not able to comply with the treatment plan

Side-Effects and Risks:

1. Opioids may cause sleepiness, respiratory depression, or death.
2. Opioids may cause decreased reaction, clouded judgment, problems with coordination and balance. When taking opioids you must be careful when driving or operating machinery. Alcohol can add to the clouding of your judgment and you should not drink and drive when taking opioids.
3. Opioids can cause or worsen sleep apnea. You should inform me/your provider if you snore a lot, if you have previously been diagnosed with sleep apnea or have any other sleeping disorders.
4. Additional side effects you could possibly experience when taking opioid pain medicine include:
   - Nausea
   - Itching
   - Sweating
   - Depression
   - Dry-mouth
   - Constipation
   - Lower testosterone levels in men with decrease in bone density
   - Infertility, fatigue, depression, anxiety, loss of muscle strength and mass and compression fractures in both men and women
   - Menstrual irregularities
   - Potential for decrease in sexual desire and performance
   - You may be prescribed other pain medications that have additional side effects and risks not listed. You will need to discuss these with your provider.
5. Side effects may be made worse if you mix opioids with other drugs.
6. Physical dependence may develop. This means it is possible that stopping the drug will cause you to miss or crave it.
7. Tolerance may develop. This means you may need more and more drug to get the same effect. When you take more medication to achieve pain relief, the risk for side effects increases.
8. Addiction. A small percentage of patients may develop addiction problems which require special treatments.
9. If you are pregnant or contemplating pregnancy, additional risks for your unborn child must be considered. You will need to discuss these risks with your provider.

Taking your medications:

1. You must take opioid medicine only as directed. Federal law prohibits selling or giving this medication to anyone else. You are responsible for securely storing your medications so others cannot have access to them.
2. Withdrawal symptoms will develop if you stop the medication abruptly.

Opioid pain medicines have risks. You acknowledge that you have had the risks of opioid treatment explained to you and you have had an opportunity to ask questions and have those questions answered.

Patient Signature: _____ Date: _____

Print Patient Name: _____ Date of Birth: _____

Physician Signature: _____ Date: _____

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Policy on Prescription Opioid Monitoring and Urine Drug Testing

The use of prescription opioids has increased over the last 10 years as an accepted method of treating chronic nonmalignant pain. At the same time there has been an increased incidence of prescription drug abuse as demonstrated by epidemiologic, emergency room, and treatment admission data. Deaths related to overdose of these medications has increased dramatically in recent years. There have been many recent stories in the news detailing the diversion of these medications from unscrupulous and unethical medical doctors for street distribution through so called "pill mills." It is the express goal of our clinic to prevent any of the medication prescribed here from being diverted for illicit use. We hope our patients share this goal.

Prescribing opioid pain medication presents the challenge to medical practitioners of finding the balance between responding to the need to relieve chronic pain and the need to prevent the overuse, abuse, or diversion of opioid medications. It is important for us to monitor the use of these medications in our clinic for a number of reasons. These include the protection of the patient, the protection of the therapy and the protection of society.

Definition of terms:
Abuse: The willful misuse of opioids, for example, to get high.
Overuse: Taking more medication than prescribed.
Diversion: Unlawful channeling of regulated pharmaceuticals from legal sources to the illicit market.
Illicit: Not legal or lawful; illegal.

In an effort to ensure our patients are compliant with their treatment plan we have instituted a policy of urine drug testing in accordance with the most recent medical literature on the subject. All new patients who are taking opioids or will be prescribed opioids by our physician will require a urine drug screen. Failure to provide a sample will disqualify you to receive this type of treatment in our office. All patients who are prescribed opioids will be subject to random urine drug screens thereafter. We also reserve the right to test any patient at any time. When you are asked to produce a urine sample, you will be asked not to leave the office until the sample is received. Once again, failure to produce a sample at the time requested will disqualify you from receiving further prescriptions for opioids.

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We utilize a point of service cup that gives us information immediately. If results are inconsistent with your treatment plan at any time, we reserve the right to discontinue opioid treatment. It is your responsibility to take your medication as prescribed. Inconsistent results include the presence of illicit substances, the presence of medications not prescribed to you or the absence of medications prescribed. Do not try to manipulate the test. Current urine drug testing methods are very sophisticated and measure the parent medication as well as the metabolites. The laboratory will be able to differentiate between samples that are consistent with treatment and samples that have been tampered with. Any confusing results will be interpreted as inconsistent. If you are taking your medication as prescribed there should not be any confusion in the results.

We understand there is a cost associated with testing. Unfortunately, this is now a necessary part of opioid therapy and is being rapidly adapted by most practitioners who prescribe opioids. While most insurances cover much of the cost of testing, it is your responsibility to pay the costs not covered by insurance.

We understand that many of our patients are elderly and obtaining a sample can be inconvenient. Nevertheless, we cannot and do not discriminate on the basis of age, sex, race, nationality, or sexual orientation and all patients will be subject to this policy.

Remember the use of these potent pain relievers is a privilege allowed in our society to improve the lives of those who have the misfortune of chronic pain. As a patient it is your responsibility to use your medication as directed. It is unlawful to sell or give your medication away. It is your responsibility to keep your medication secured and away from children or others who may misuse or divert. It is all of our responsibility to protect this therapy for the benefit of patients with chronic pain.

This policy may be amended from time to time in accordance with new medical findings or legislative mandates.

Patient Signature:_____

Date:_____

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NAME: _____ DATE: _____

DRUG USE QUESTIONNAIRE (DAST – 20)

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question. In the statements "drug abuse" refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquillizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions **do not** include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

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Adult Version

These questions refer to the past 12 months.	**Circle Your Response**	
1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Have you abused prescription drugs?	Yes	No
3. Do you abuse more than one drug at a time?	Yes	No
4. Can you get through the week without using drugs?	Yes	No
5. Are you always able to stop using drugs when you want to?	Yes	No
6. Have you had "blackouts" or "flashbacks" as a result or drug use?	Yes	No
7. Do you every feel bad or guilty about your drug use?	Yes	No
8. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
9. Has drug abuse created problems between you and your spouse or your parents?	Yes	No
10. Have you lost friends because of your use of drugs?	Yes	No
11. Have you neglected your family because of your use of drugs?	Yes	No
12. Have you been in trouble at work (or school) because of drug abuse?	Yes	No
13. Have you lost your job because of drug abuse?	Yes	No
14. Have you gotten into fights when under the influence of drugs?	Yes	No
15. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
16. Have you been arrested for possession of illegal drugs?	Yes	No
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No
19. Have you gone to anyone for help for drug problem?	Yes	No
20. Have you been involved in a treatment program specifically related to drug use?	Yes	No

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As a part of our pain management procedure, we need your correct phone number at all times.

We may call you at any time to come in for a pill count. If you are called, you will be expected to be in our office within 24 hours of that call for your pill counting.

Thank you

Patient Signature: _____

Phone Number: _____

Date: _____

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