MISSION PAIN AND SPINE

26932 Oso Parkway, Suite 275

Mission Viejo, CA 92691

(949) 916-8100 FAX (949) 916-8555

INFORMED CONSENT AGREEMENT FOR TREATMENT OF INTRACTABLE PAIN WITH NARCOTIC MEDICATION

I understand that there are alternatives to narcotic drug therapy which I have discussed with my doctor.

The goal of my therapy is to reduce my pain to a level that is tolerable and that will allow me to improve my daily function.

I understand that any narcotic use may increase certain risks, which include, but are not limited to:

- Addiction
- Nausea, vomiting, and constipation
- Impair judgement, sleepiness, and confusion
- Allergic reactions, overdose, and fatal complications
- Breathing problems
- Dizziness
- Impaired ability to operate machines or drive motor vehicles
- Development of tolerance, physical dependence, and opioid induced hyperalgesia (increased pain due to chronic use of narcotics)

I agree to the following guidelines (initial):

____I will take this medication as prescribed by my provider. I will not vary the dose or interval without approval from my provider.

____I will submit random urine and blood tests if requested by my provider to assess my compliance.

____I will obtain all my prescriptions for pain through providers of Mission Pain and Spine and will fill my prescriptions at _____pharmacy.

____Due to the potential for misuse, I know that I will be unable to obtain early refills or replacements of lost or stolen medication. Refills will only be made during regular business hours.

____I agreed to see providers of Mission Pain and Spine and for ongoing pain management and will schedule regular appointment as long as I am taking narcotic medication.

____If I do not follow these guidelines I understand my narcotic treatment may be terminated.

____I understand that driving a motor vehicle or heavy machinery is not recommended while using controlled narcotic medication and I will not hold Mission Pain and Spine or its Physicians responsible for any injuries resulting in any type of accident, vehicle, or otherwise. It is my full responsibility to comply with the laws of the state of California while taking controlled narcotic medication.

_____	_____	_____	_____.
Patient Signature	Date	Provider Signature	Date

_____	_____
Print Name	Date of Birth