Patient name: _____

PRESCRIPTION MEDICATION AGREEMENT FOR CONTROLLED SUBSTANCE TREATMENT OF PAIN

Nevada law requires a patient to enter into a "Prescription Medication Agreement" if a controlled substance is to be continued for more than 30 days for treatment of pain. I understand that this agreement will be updated every 365 days, or if there is a change to my treatment plan. I understand that attempting to reduce my pain is my responsibility, and that the treatment of pain with controlled substances carries with it some additional responsibilities of which my practitioner has made me aware. The purpose of this agreement is to help both me and my practitioner comply with the law.

(Please initial within each numbered paragraph and sign below to indicate your understanding of all parts of this document.)

Regarding my treatment plan and he goals of the treatment of my pain, including the appropriate use of a controlled substance.

_____I have discussed my treatment plan with my practitioner and I have a good understanding of the overall treatment plan and goals of treatment. My practitioner has discussed possible alternative treatments for my pain that do not include controlled substances and it is our mutual decision that continuation of a controlled substance for more than 30 days may provide some benefit for the treatment of my pain.

_____ I understand that part of the goals of my pain management therapy may be to minimize or even to discontinue the use of controlled substances. There may be various reasons that my practitioner will recommend tapering or discontinuation of a controlled substance. Some of these reasons may include, but are not limited to: a reduction of pain symptoms by other means; the presence or development of side effects; any signs of misuse, abuse, diversion, or addiction; refusal to comply with diagnostic studies or other aspects of the treatment plan; attempts to obtain medication from other providers; use of illicit drugs or other medications that may interact with the controlled substance; or any other reason that my practitioner may deem it in my best interest to reduce or discontinue the controlled substance.

_____ I hereby reaffirm my consent to monitor my drug use when my practitioner deems it appropriate or necessary, including, without limitations, urine, hair, and blood testing as well as bringing my medications to the prescriber's office where the number of pills may be counted.

_____ I reaffirm that I will take the prescribed controlled substance only as prescribed.

_____ I will not share my medication with any other person.

_____ I agree to inform my practitioner of any other controlled substance prescribed to me or taken by me.

_____ I will immediately disclose to my practitioner of any alcohol consumed by me and of any marijuana products, including cannabinoids, I may use or consume while taking the controlled substance for the treatment of my pain.

Patient name: _____

PRESCRIPTION MEDICATION AGREEMENT FOR CONTROLLED SUBSTANCE TREATMENT OF PAIN

_____ I will disclose to my practitioner whether I have been treated for side effects or complication relating to the use of the controlled substance, including whether I have experienced an overdose.

_____ I understand that Nevada state law requires me to provide a listing of every State in which I have previously resided or had a prescription for a controlled substance filled. Below is a listing of such states:

_____ I understand how to properly use the controlled substance that is being prescribed, and I agree to take the medication as directed and to not deviate from the parameters of the prescription as written by my practitioner. I will keep the medication safe, secure, and out of the reach of children, and I will dispose of unused medication appropriately.

_____ I understand the risks and benefits associated with the use of controlled substances for the treatment of pain for greater than 30 days, including the risk of abuse, misuse, tolerance, dependence, and addiction.

_____ I understand that prescriptions will only be provided during scheduled office visits, and it is my responsibility to make sure that I have scheduled an appointment for refills (typically 30 days in advance).

_____ I understand that my medication is my responsibility and if it is lost or stolen, the medication may not be replaced until my next appointment, at the judgment of my prescriber.

_____ If my treatment for pain goes beyond ninety (90) days, I realize that I will be required by Nevada law to complete an assessment regarding my risk for abuse, 3 dependency and addiction using validated tests. I agree to cooperate for those tests. I understand I will also be required to undergo appropriate testing to determine an evidence based diagnosis for the cause of my pain. My practitioner may also refer me to a specialist for consultation or for further treatment.

I hereby authorize my practitioner to obtain records from other practitioners or clinics, and speak to other practitioners about my current or prior medical care.

_____ It is my responsibility to provide the office or clinic with my current and updated contact information in order to facilitate communication.

Patient name: _____

PRESCRIPTION MEDICATION AGREEMENT FOR CONTROLLED SUBSTANCE TREATMENT OF PAIN

_____ I authorize my practitioner and my pharmacy to cooperate fully with any city, state, or federal law enforcement agencies investigation, including, but not limited to Drug Enforcement Administration, State Board of Pharmacy, or State Occupational Licensing Boards.

I agree to fill my prescriptions from only one pharmacy, unless the medication is not available at that pharmacy or the costs of the medication are substantially better at another pharmacy. I will immediately notify my practitioner if I change or use another pharmacy.

My current pharmacy is:

_____ _____

Pharmacy Name Pharmacy Phone Number

_____

Pharmacy Address

I understand that if I violate any part of this agreement, I may be denied prescriptions for controlled substances and I may be discharged from the clinic.

I have read and understand each of the statements written above and have had an opportunity to have all my questions answered. By signing, I agree to abide by the rules of this Prescription Medication Agreement while continuing to receive prescriptions of controlled substances for treatment of my pain.

_____ _____ _____

Patient Signature Patient name printed Date

_____ _____ _____

Parent/Guardian Parent/Guardian name printed Date

Patient name: _____

Opioid Therapy for Chronic Pain: Informed Consent

Please review the information listed here and put your initials next to each item when you have reviewed it with your provider and feel you understand and accept what each statement says.

My provider is prescribing opioid pain medications:

_____ When I take these medications, I may experience certain reactions or side effects that could be dangerous, including sleepiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing of my breathing.

_____ When I take these medications it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused, or otherwise impaired by these medications, I should not do things that would put other people at risk for being injured.

_____ When I take these medications regularly, I will become physically dependent on them, meaning that my body will become accustomed to taking the medications every day, and I would experience withdrawal sickness if I stop them or cut back on them too quickly. Withdrawal symptoms feel like having the flu, and may include abdominal pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, yawning, anxiety, and sleep problems.

_____ I may become addicted to these medications and require addiction treatment if I cannot control how I am using them, or if I continue to use them even though I am having bad or dangerous things happen because of the medications.

_____ Anyone can develop an addiction to opioid pain medications, but people who have had problems with mental illness or with controlling drug or alcohol use in the past are at higher risk. I have told my provider if I or anyone in my family has had any of these types of problems.

_____ Taking too much of my pain medication, or mixing my pain medications with drugs, psychiatric medicine, or other medications that cause sleepiness, such as benzodiazepines, barbiturates, and other sleep aids, could cause me to be dangerously sedated or to overdose and stop breathing.

_____ I understand that taking certain medications such as buprenorphine (Suboxone®, It is my responsibility to tell any provider that is treating me or prescribing me medications that I am taking opioid pain medications so that they can treat me safely and do no Subutex®, naltrexone (ReVia®), nalbuphine (Nubain®), pentazocine (Talwin®), or butorphanol (Stadol®) will reverse the effects of my pain medicines and cause me to go into withdrawal.

_____ It is my responsibility to tell any provider that is treating me or prescribing me medications that I am taking opioid pain medications so that they can treat me safely and do not give me any medicines that may interact dangerously with my pain medicines.

Patient name: _____

Opioid Therapy for Chronic Pain: Informed Consent

_____ I have discussed the possible risks and benefits of taking opioid medications for my condition with my provider and have discussed the possibility of other treatments that do not use opioid medications.

_____ These medications are being prescribed to me because other treatments have not controlled my pain well enough.

_____ These medications are to be used to decrease my pain but they will not take away my pain completely.

_____ These medications are to be used to help improve my ability to work, take care of myself and my family, and meet other goals that I have discussed with my provider, but if these medications do not help me meet those goals, they will be stopped.

For Men: _____ Taking opioid pain medications chronically may cause low testosterone levels and affect sexual function.

For Women: _____ It is my responsibility to tell my provider immediately if I think I am pregnant or if I am thinking about getting pregnant. If I become pregnant while taking these medications and continue to take the medicines during the pregnancy, the baby will be physically dependent on opioids at the time of birth and may require withdrawal treatment.

I have reviewed this form with my provider and have had the chance to ask any questions. I understand each of the statements written here and by signing give my consent for treatment of my pain condition with opioid medications.

_____	_____	_____
Patient signature	Patient name printed	Date
_____	_____	_____
Provider signature	Provider name printed	Date

Patient name: _____ Date: _____

COMM™

Please answer each question as honestly as possible. Keep in mind that we are only asking about the past 30 days. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	O	O	O	O	O
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	O	O	O	O	O
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	O	O	O	O	O
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	O	O	O	O	O
5. In the past 30 days, how often have you seriously thought about hurting yourself?	O	O	O	O	O
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	O	O	O	O	O

Patient name: _____ Date: _____

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
7. In the past 30 days, how often have you been in an argument?	O	O	O	O	O
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	O	O	O	O	O
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	O	O	O	O	O
10. In the past 30 days, how often have you been worried about how you're handling your medications?	O	O	O	O	O
11. In the past 30 days, how often have others been worried about how you're handling your medications?	O	O	O	O	O
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	O	O	O	O	O
13. In the past 30 days, how often have you gotten angry with people?	O	O	O	O	O
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	O	O	O	O	O
15. In the past 30 days, how often have you borrowed pain medication from someone else?	O	O	O	O	O
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	O	O	O	O	O
17. In the past 30 days, how often have you had to visit the Emergency Room?	O	O	O	O	O

Patient Name: _____ Date: _____

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.

0 I do not feel sad.
1 I feel sad
2 I am sad all the time and I can't snap out of it.
3 I am so sad and unhappy that I can't stand it.

2.

0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel the future is hopeless and that things cannot improve.

3.

0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

4.

0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5.

0 I don't feel particularly guilty
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6.

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished. 3
I feel I am being punished.

7.

0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8.

0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9.

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

Patient Name: _____ Date: _____

10.

0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15.

0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.

0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.

0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

Patient Name: _____ Date: _____

19.

0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.

0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score_____

Levels of Depression

1-10_____These ups and downs are considered normal
11-16_____ Mild mood disturbance
17-20_____Borderline clinical depression
21-30_____Moderate depression
31-40_____Severe depression
over 40_____Extreme depression

_____

Patient's Name

Controlled Substance Questionnaire

	YES	NO	N/A
N/A means not applicable.			
Have you ever used a controlled substance in a way other than prescribed?	____	____	____
Have you ever diverted a controlled substance to another person?	____	____	____
Have you ever taken a controlled substance that did not have the desired effect?	____	____	____
Are you currently using any drugs, including alcohol or marijuana?	____	____	____
Are you using any drugs that may negatively interact with a controlled substance?	____	____	____
Are you using any drugs that were not prescribed by a practitioner that is treating you?	____	____	____
Have you ever attempted to obtain an early refill of a controlled substance?	____	____	____
Have you ever made a claim that a controlled substance was lost or stolen?	____	____	____
Have you ever been questioned about your pharmacy report or PMP report?	____	____	____
Have you ever had blood or urine tests that indicate inappropriate usage of meds?	____	____	____
Have you ever been accused of inappropriate behavior or intoxication?	____	____	____
Have you ever increased the dose or frequency of meds without telling your provider?	____	____	____
Have you ever had difficulty with stopping the use of a controlled substance?	____	____	____
Have you ever demanded to be prescribed a controlled substance?	____	____	____
Have you ever refused to cooperate with any medical testing or examinations?	____	____	____
Have you ever had a history of substance abuse of any kind?	____	____	____
Has there been any change in your health that might affect your medications?	____	____	____
Have you misused or become addicted to a drug, or failed to comply with instructions?	____	____	____
Are there any other factors that your practitioner should consider before prescribing?	____	____	____

_____	_____	_____
Patient's Signature	Patient's Printed Name	Date
_____	_____	_____
Parent/Legal Guardian	Parent/Legal Guardian	Date

Patient Name: _____ Date: _____

PRESCRIPTION OPIOD MISUSE INDEX

1. Do you ever use MORE of your medication, that is, take a higher dosage, than is prescribed for you? Yes No

2. Do you ever use your medication MORE OFTEN, that is, shorten the time between dosages? Yes No

3. Do you ever feel high or get a buzz after using your pain medication? Yes No

4. Do you ever take your pain medication because you are upset, using the medication to relieve or cope with problems other than pain? Yes No

5. Have you ever gone to multiple physicians including emergency room doctors, seeking more of your pain medication? Yes No

6. Do you ever need early refills for your pain medication? Yes No