APPENDIX G: PATIENT UNDERSTANDING FOR OPIOID TREATMENT FORM

Patient understanding fir Opioid Treatment Form

Healthcare Provider Name:

Patient Name:

WCB Claim #:

I am taking a pain medicine called OPIOIDS to help improve my pain.

I agree (the patient must initial each point below to show agreement)

|  |  |
| --- | --- |
| \_\_\_\_l will take my pain medicine exactly the way my doctor tells me to. That means I will take the right amount of pain medicine at the right time. | \_\_\_\_I will do what I can to get back to work. |
| \_\_\_\_I will tell my doctor about any new medical problems. | \_\_\_\_I will not drink alcohol or use any other drugs unless I am told to do it by my doctor. |
| \_\_\_\_I will tell my doctor about all medicine I take, and will tell my doctor lf l am given any new medicines. | \_\_\_\_When I am asked, I will get lab tests to see If I am taking my medicines the right way. |
| \_\_\_\_I will tell my doctor if I see another doctor, or if I go to the Emergency Room. | \_\_\_\_If the lab tests show that I am not taking the medicines the way I should, my doctor may cut down or stop my medicine or send me to a specialist or special program to help care for me. |
| \_\_\_\_I Will only get my pain medicine prescription from this doctor. My doctor's name is listed on the top of this page. | \_\_\_\_I will store my pain medicine in a safe place where other people cannot take it |
| \_\_\_\_If my doctor is away, I will only get medicine from the doctor who is in charge while my doctor is away. | \_\_\_\_I will keep my scheduled appointments. If I must miss an appointment, I will call my doctor to cancel at least 24 hours before the appointment. |
| \_\_\_\_I will only get my pain medicine from one pharmacy (drug store). | \_\_\_\_My doctor may stop giving me pain  medicine if:  • I do not follow this agreement.  • The pain medicine is not helping me.  • I'm not meeting my goals in active therapy.  • My pain or my functions do not improve.  • I have bad side effects from the pain medicine.  • I become addicted to the pain medicine.  • I give or sell the pain medicine to someone else. |
| \_\_\_\_I will follow my doctor's directions about therapy, exercises and physical things to do so I can learn to live with my pain. | \_\_\_\_I am not-pregnant and i will call my doctor as soon as possible If l think l may be pregnant. |

Patient Signature: Date:

I attest that this form was reviewed by me with the patient and all questions were answered.

Healthcare Provider Name: Date