Appendix F: Patient Informed Consent for Opioid Treatment Form

PATIENT INFORMED CONSENT FOR OPIOID TREATMENT FORM

I plan to take a pain medicine called OPIOIDS. This pain medicine may help improve my pain but It may also cause some serious problems. The problems may be worse if mix the pain medicine with alcohol or other drugs.

I understand that the pain medicine I will be taking may cause serious problems including:

* Confusion
* Poor Judgment.
* Nausea (a stomach ache).
* Vomiting.
* Constipation (hard stools that may be painful to push out).
* Sleepy or drowsy feeling.
* Poor coordination and balance (such as feeling unsteady, tripping, and falling).
* Slow reaction time.
* Slow breathing or I can stop breathing- which could cause me to die.
* More depression (such as feeling sad, hopeless, or unable to do anything).
* Dry mouth.
* Increased feeling of pain (hyperalgesia).
* Addiction (it may be very hard to stop taking the pain medicine when I'm ready to quit).
* For men: the pain medicine may lead to less interest In sex and poor sexual performance.
* For pregnant women, the pain medicine may hurt my unborn child and may cause my child to be born addicted to the pain medicine.

I will tell my doctor if I have any of the problems listed here.

I understand there may be other problems caused by the pain medicine, in addition to the problems listed here.

I understand that these problems may get better when I stop taking the pain medicine.

My doctor has reviewed the serious problems that this pain medicine may cause. My doctor has answered all questions that I have about this pain medicine and the serious problems it may cause.

Patient Signature: Date:

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

Doctor Signature: Date: