CONTROLLED SUBSTANCE AGREEMENT FOR USING PRESCRIPTION OPIOIDS AND OTHER CONTROLLED SUBSTANCES

I understand and acknowledge that prescriptions for controlled substances will not be issued at the time of initial consultation in accordance with clinic policies.*

Controlled substances are high-risk medications that are issued only when clinically appropriate and after completion of the screening process recommended by Utah State Guidelines.**

PRINTED NAME: ____ DATE: _______________

SIGNATURE: ____ DATE: _______________

*rare exceptions may exist

**Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain, available at https://health.ut.gov/vipp/pdf/RxDrugs/UtahClinicalGuidelinesonPrescribing.pdf

CONTROLLED SUBSTANCE AGREEMENT USING PRESCRIPTION OPIOIDS AND OTHER CONTROLLED SUBSTANCES

PATIENT NAME: ____

THE PURPOSE OF THIS AGREEMENT IS TO STRUCTURE OUR PLAN TO WORK TOGETHER TO TREAT YOUR CHRONIC PAIN AND OTHER CONDITIONS REQUIRING CONTROLLED SUBSTANCES. THIS WILL PROTECT YOUR ACCESS TO OPIOID PAIN MEDICATIONS AND OUR ABILITY TO PRESCRIBE THEM TO YOU.

I (patient) understand the following (initial each):

_______ Opioids/controlled substances have been prescribed to me on a trial basis. One of the goals of this treatment is to improve my ability to perform various functions, including returning to work. If significant demonstrable improvement in my functional capabilities does not result from this trial of treatment, my prescriber may determine to end the trial.

_______ Goal for improved function: See Initial Evaluation and subsequent follow-up visits.

_______ Opioids/controlled substances are being prescribed to make my pain/symptoms tolerable but may not cause it/them to disappear entirely. If this goal is not reached, my medical provider may end the trial.

_______ Goal for reduction of pain/symptoms: See Initial Evaluation and subsequent follow-up visits.

______ Drowsiness and slowed reflexes can be a temporary side effect of opioids, especially during dosage adjustments. If I am experiencing drowsiness while taking opioids, I agree to not drive a vehicle or perform other tasks that could involve danger to myself or others.

______ Using opioids to treat chronic pain will result in the development of physical dependence. Sudden decreases or discontinuation of the medication will lead to symptoms of opioid withdrawal. These symptoms can include runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, vomiting, irritability, depressed mood, aches, and flu-like symptoms. I understand that opioid withdrawal is uncomfortable but not physically life threatening.

_______ There is a small but significant risk that opioid psychological dependence (addiction) can occur. If I may be developing addiction, my medical provider may determine to end the trial.

______ The patient education, as discussed above, applies to all controlled substances, though usage and adverse effects (including dependence and addiction) of medications vary. Your medical provider will address other controlled substances if they are a part of your treatment program.

I agree to the following (initial each):

_______ I agree to take medication(s) as prescribed. Using medications at a faster rate orincreased dose other than prescribed may result in death.

_______ I agree to have regular office visits as decided by my medical provider. I understand that this agreement will be null and void if more than 15 days elapse past my anticipated, regular appointment time.

_______ I agree to keep the prescribed medication in a safe and secure place, and that lost,damaged, or stolen medication will not be replaced.

_______ I agree not to share, sell, or in any way provide my medication to any other person.

_______ I agree to obtain prescription medication from one designated licensed pharmacist. I understand that my medical provider may check the Utah Controlled Substance Database at any time to check my compliance.

_______ I agree not to seek or obtain **ANY** mood-modifying medication, including pain relievers or tranquilizers from **ANY** other prescriber without first discussing this with my prescriber. If a situation arises in which I have no alternative but to obtain my necessary prescription from another prescriber, I will advise that prescriber of this agreement. I will then immediately advise my prescriber that I obtained a prescription from another prescriber.

_______ I agree to refrain from the use of **ALL** other mood-modifying drugs (prescription and illicit), including alcohol and marijuana. My medical provider may prescribe other controlled substances as part of my treatment plan.

_______ I agree to submit to random urine or blood for drug testing at my prescriber's request. I understand that it is my responsibility to pay for drug screening if self-pay or if it is not covered by insurance. I agree to have random pill counts at my prescriber's request. I must have access to a telephone and be able to be reached by telephone within 24 hours. Drug testing and pill counts verify compliance with my treatment plan. If I cannot produceurine or blood at the time requested, this will be grounds for termination of pain management services. I agree to being seen by an addiction specialist if requested.

_______ I agree to attend and participate fully in any other assessments of pain treatment programs which may be recommended by the prescriber at any time. In consideration of my treatment goals, I agree to help myself by following better health habits, including exercise, smoking cessation, and weight control.

_______ I agree to attend and participate fully in a mental health evaluation and/or treatment for mental health disorders (i.e. depression, anxiety, etc) as may be recommended by the prescriber at any time

_______ I understand that this contract also applies to any and all controlled substances that are part of my total treatment program, not just limited to pain management.

I UNDERSTAND THAT ANY DEVIATION FROM THE ABOVE AGREEMENT WILL BE GROUNDS FOR TERMINATION OF CONTROLLED SUBSTANCE PRESCRIBING SERVICES AT ANY TIME.

MEDICATIONS COVERED BY THIS AGREEMENT:

____

____

____

____

____

____

PHARMACY: ____

ADDRESS: ____ CITY: ___________

PHONE: _____________________________

_____________________________________ ______________

PATIENT SIGNATURE DATE

VIOLATIONS:

____

____

____

____

____

DATE OF VIOLATION: ________________________ LETTER OF TERMINATION? YES

PATIENT HEALTH QUESTIONNAIRE – 9 (PHQ-9)				
Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING ________ + _______ + ________ + _______

= TOTAL SCORE _______

If you checked of <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all   Somewhat difficult   Very difficult   Extremely difficult

Developed by Drs. Robert L. Spitzer, Janet B. W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

GENERALIZED ANXIETY DISORDER 7-ITEM (GAD-7) SCALE				
Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column		+	+	+
Total Score (add your column scores) =				

If you checked of <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Source: Spitzer RL, Kroenke K, Williams JBW, Lower B. A. brief measure for assessing generalized anxiety disorder. Arch Inern Med. 2006; 166; 1092-1097.

The following are some questions given to all patients at Advanced Spine and Pain, PLLC who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

SOAPP VERSION 1.0-14Q					
Please answer the questions below using the following scale:	Never	Seldom	Sometimes	Often	Very Often
1. How often do you have mood swings?	0	1	2	3	4
2. How often do you smoke a cigarette within an hour after you wake up?	0	1	2	3	4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0	1	2	3	4
4. How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4
5. How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
6. How often have you attended an AA or NA meeting?	0	1	2	3	4
7. How often have you taken medication other than the way it was prescribed?	0	1	2	3	4
8. How often have you been treated for an alcohol or drug problem?	0	1	2	3	4
9. How often have your medications been lost or stolen?	0	1	2	3	4
10. How often have others expressed concern over your use of medication?	0	1	2	3	4
11. How often have you felt a craving for medication?	0	1	2	3	4
12. How often have you been asked to give a urine screen for substance abuse?	0	1	2	3	4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the last five years?	0	1	2	3	4
14. How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4

Please include any additional information you wish about the above answers. Thank you.

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ASAP | ADVANCED SPINE AND PAIN

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PATIENT COPY

Naloxone for Overdose Prevention

patient name

date of birth

patient address

patient city, state, ZIP code

Jeremy Joyal, MD NPI 1861622219
prescriber name

11760 S. 700 E. Suite 112
prescriber address

Draper, UT 84020
prescriber city, state, ZIP code

801-572-1186
prescriber phone number

Naloxone HCl 0.4 mg/mL (Narcan)
1 x 10 mL as one fliptop vial (NDC 0409-1219-01) OR
2 x 1mL single dose vials (NDC 0409-1215-01)

Refills: _____

Intramuscular (IM) syringe, 23 G, 3cc, 1 inch

Qty: _____ Refills: _____

Sig: For suspected opioid overdose,
inject 1mL IM in shoulder or thigh.
Repeat after 3 minutes if no or minimal response.

prescriber signature

date

Detach for patient

Are they breathing?

Signs of an overdose:

- Slow or shallow breathing
- Gasping for air when sleeping or weird snoring
- Pale or bluish skin
- Slow heartbeat, low blood pressure
- Won't wake up or respond (rub knuckles on sternum)

Call 911 for help

All you have to say:
"Someone is unresponsive and not breathing."
Give clear address and location.

Airway

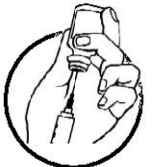
Make sure nothing is inside the person's mouth.

Rescue breathing

Oxygen saves lives. Breathe for them.
One hand on chin, tilt head back, pinch nose closed.
Make a seal over mouth & breathe in
1 breath every 5 seconds
Chest should rise, not stomach

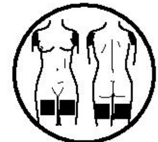
Evaluate

Are they any better? Can you get naloxone and prepare it quickly enough that they won't go for too long without your breathing assistance?



Prepare naloxone

- Remove cap from naloxone and uncover needle
- Insert needle through rubber plug, with bottle upside down
- Pull back on plunger and take up 1 cc into the syringe
- Don't worry about air bubbles (they aren't dangerous in muscle injections)



Muscular injection

inject 1cc of naloxone into a big muscle (shoulder or thigh)

Evaluate + support

- Continue rescue breathing
- Give another shot of naloxone in 3 minutes if no or minimal breathing or responsiveness
- Naloxone wears off in 30-90 minutes
- Comfort them; withdrawal can be unpleasant
- Get them medical care and help them not use more opiate right away
- Encourage survivors to seek treatment if they feel they have a problem

How to Avoid Overdose

- Only take medicine prescribed to you
- Don't take more than instructed
- Call a doctor if your pain gets worse
- Never mix pain meds with alcohol
- Avoid sleeping pills when taking pain meds
- Dispose of unused medications
- Store your medicine in a secure place
- Learn how to use naloxone
- Teach your family + friends how to respond to an overdose

For More Info
PrescribeToPrevent.com

Poison Center
1-800-222-1222
(free & anonymous)

v01.2012.1