KRSI
KATRANJI RECONSTRUCTIVE SURGERY INSTITUTE

Katranji Reconstructive Surgery Institute
2111 Merritt Road
East Lansing, MI 48823

Pain Medication Contract

This is an agreement between _____ (the "Patient") and Dr. _____(the "Physician") concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of a chronic pain problem. The Patient understands that the medication will not completely eliminate the pain, but is expected to reduce it so that Patient may become more functional and improve Patient's quality of life.

1. I, the Patient, understand that opioid analgesics are strong medications for pain relief and have been informed of all the risks and side effects associated with them.

2. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication dosage, I could potentially experience withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) within 24-48 hours of the last dose. I understand that opioid withdrawal is an uncomfortable and bothersome feeling, but not a life-threatening condition.

3. I understand that if I am pregnant or become pregnant while taking these opioid medications, my child could be physically dependent on the opioids and withdrawal can be life-threatening for the baby.

4. I further understand that overdosing on this medication can potentially lead to my death by stopping my breathing. This can be reversed by emergency medical personnel if they are aware I have taken narcotic pain-killers. It is suggested by the Physician to wear a medical alert bracelet or necklace that contains this information. '

5. In the event the medication causes drowsiness, sedation, or dizziness, I understand that I shall refrain from driving a motor vehicle or operating any machinery, as that could put my life or someone else's life in jeopardy.

6. I further understand that it is my responsibility to inform the Physician of any and all side effects I may receive from the taking of this medication.

7. I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. I understand and acknowledge that the Physician may discontinue prescribing such medication if it is deemed that I am running out early, needing early refills, escalating doses without permission, and/or losing prescriptions, as these signs indicate possible misuse of the medication.

8. I agree that the opioids will be prescribed by only <u>one</u> physician and I agree to fill my prescriptions at only <u>one</u> pharmacy. I agree not to take any pain medication or mind-altering medication prescribed by any other physician without first discussing it with the above-named physician. I give permission for the physician to verify that I am not seeing other physicians for opioid medication or going to other pharmacies.

9. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced.

10. I agree not to sell, lend, or in any way give my medication to any other person.

11. I agree not to drink alcohol or take other mood-altering drugs while I am taking opioid analgesic medication. I agree to submit a urine specimen at any time that my physician requests and give my permission for it to be tested for alcohol and drugs.

12. I agree that I will attend all required follow-up visits with the physician to monitor this medication and I understand that failure to do so will result in discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities recommended by my physician.

13. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.

14. I hereby RELEASE AND DISCHARGE Physician and its officers, directors, agents, and employees (hereinafter collectively called the "Released Parties"), from any and all liability, claims, demands or causes of action that I, my successors, administrators, heirs, and assigns may hereafter have for injuries/damages arising out of my participation in the medication (initial here _____)

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15. I understand and acknowledge that medication mentioned in this agreement has potential dangers and side effects that no amount of care, caution, instruction, or expertise can eliminate and I EXPRESSLY AND VOLUNTARILY ASSUME ALL RISK OF DEATH OR PERSONAL INJURY SUSTAINED WHILE TAKING SUCH MEDICATION (initial here_____)

16. I further agree that I WILL NOT SUE OR MAKE A CLAIM against the Released Parties for damages or other losses sustained as a result of taking such medication. (initial here_____)

17. I also agree to INDEMNIFY AND HOLD THE RELEASED PARTIES HARMLESS from all claims, judgments, and costs, including attorneys' fees, incurred in connection with any action brought as a result of my taking such medication. (initial here_____)

18. I will take full responsibility for, and hold harmless Released Parties for, any injury that I may suffer or inflict upon others or their property as a result of my taking of such medication. (initial here_____)

19. I agree that I will use the medication in a reasonable and safe manner, as prescribed to me by my Physician. (initial here_____)

I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the physician may discontinue this form of treatment.

_____

Printed name of patient

_____ _____

Signature of patient **Date**

_____ _____

Signature of KRSI Staff **Date**