INTERVENTIONAL SPINE & REHAB OF LOUISIANA
ISRLouisiana.com
PH 225-263-0600 FAX 225-263-0601
4021 WE Heck Ct. Building M-1 Baton Rouge, LA 70816
MARK JOHN, M.D.
PHYSICAL MEDICINE & REHABILITATION
INTERVENTIONAL PAIN MANAGEMENT

Opioid Consent

Please review the information below and initial next to each item accepting what each statement says.

_____ Dr. John is prescribing opioid pain medications to help control my overall pain.
_____ When I take these medications, I may experience certain reactions or side effects that could be dangerous, including but not limited, to 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 may become physically dependent on them, meaning that my body will be 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, but not limited to, abdominal pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, running 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 medication 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, Subutex), naltrexone (ReVia), nalbuphine (Nubain), pentazocine (TalWin), or butorphanol (Stadol), will reverse the effects of my pain medications 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 medications.
_____ I have discussed the possible risks and benefits of taking opioid medications for my condition with Dr. John and have discussed the possibility of other treatments that do not use opioid medications, including, but not limited to: therapy, injections/procedures, surgery, exercise, or acupuncture.
_____ 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 may 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, improve my overall function, and meet other goals that I have discussed with Dr. John, but if these medications do not help me meet my goals, they will be stopped.
_____ **For Men**: Taking opioid pain medications chronically may cause low testosterone levels and effect sexual function.
_____ **For Women**: It is **my responsibility** to tell Dr. John immediately if I think I am pregnant or if I plan on becoming pregnant. If I become pregnant while taking these medications and continue to take the medications 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 Dr. John 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
_____	Markus V. John	_____
Provider Signature	Provider Name Printed	Date

Revised: 02/20/2019

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Opioid Risk Tool

Date: _____

Patient Name: _____

Directions: Question 1 applies to immediate family members. Questions 2-5 apply to yourself. Please mark ONLY the boxes that apply. Please disregard the numbers to the right of the boxes.

				Female	Male
1.	Family history of substance abuse	Alcohol	[ ]	1	3
		Illegal Drugs	[ ]	2	3
		Prescription Drugs	[ ]	4	4
2.	Personal history of substance abuse	Alcohol	[ ]	3	3
		Illegal Drugs	[ ]	4	4
		Prescription Drugs	[ ]	5	5
3.	Age (Mark box if 16-45)		[ ]	1	1
4.	History of preadolescent Sexual Abuse		[ ]	3	0
5.	Psychological Disease (including any of the following): Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia		[ ]	2	2
6.	Depression		[ ]	1	1

None of these apply [ ]

Signature _____

*** In order to be considered for medication management, this form must be filled out in its entirety.

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Pain Management Treatment Agreement _____

When other pain management treatment options are unavailable or have proven ineffective, Opioid (narcotic) medications may be considered to improve quality of life, as well as the ability to function and work. While all medications have possible side effects, Opioid medications are potentially more dangerous with respect to side effects and/or risks. The side effects and risks are discussed with you at the beginning of treatment and periodically thereafter. The facility's goal is to improve the patient's quality of life and the ability to function and/or work. To ensure safe usage and pain control, proper monitoring through drug testing is required. We ask our patients to carefully read, agree and comply with the following conditions. **NON-COMPLIANCE WITH ANY ONE OF THESE CONDITIONS MAY RESULT IN DISCHARGE FROM THE PRACTICE.**

- I will not ask my doctor to phone in any pain medication for me, as it is against the office's policy. It is **my responsibility** to plan ahead, arrive for office visits as scheduled and take any medications as directed to prevent running short of medication before my next appointment.
- Opioid prescription refills are available **only** through a scheduled visit during regular office hours. I understand I may experience medication withdrawal symptoms if I miss my appointment.
- I will keep all scheduled appointments with my doctor.
- Interventional Spine and Rehabilitation of Louisiana (ISRL) **must be** the **ONLY** source for the following medication in addition to any and all controlled substances (if being prescribed by Dr. Mark John):
  - Oxycodone (Percocet), Hydrocodone (Norco), Fentayl (Duragesic Patch), Barbiturates (Fioricet), etc.
- I understand that Dr. Mark John **does not** prescribe the following (**NO EXCEPTIONS WILL BE MADE**):
  - Benzodiazepines (Valium, Xanax, Ativan, etc.), Methadone, Roxicodone, Suboxone, Carisoprodol (Soma)
- I **will not** accept any pain medications from any other physician, and I will **alert** my other physicians of my narcotic treatment with ISRL.
- I will **NOT** go to the emergency room for pain management of my chronic condition for which my doctor is currently treating me, unless told to do so.
- I will **immediately notify** ISRL staff if I receive emergency/other medical treatment for any other reason.
- I will use my pain medications as prescribed, no more than prescribed, nor make any modifications to the prescribed dosages, and I will not give my prescriptions to anyone else, nor will I accept pain medications from another individual. I understand that sharing narcotic medications is absolutely forbidden and is against the law.
- I agree to use **ONLY** the pharmacy listed below to fill my medications. I will notify ISRL staff if my pharmacy changes or if I need to fill my medications at another pharmacy for whatever reason.

Pharmacy Name and Location: _____

- I consent for my doctor, his associates, and medical staff to communicate directly with my pharmacy to obtain information regarding my prescription history. I agree to waive any applicable privilege or right to confidentiality with respect to the prescribing of my pain medication. I authorize Dr. Mark John and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the Louisiana Board of Pharmacy, in the investigation of my possible misuse, sale, or diversion of my pain medication. I authorize a copy of this agreement to be provided to my pharmacy and consulting physician.
- I agree to adhere to all conditions from Dr. Mark John and pharmacy for safe use of my medications.
- I agree to refrain from all mind/mood altering drugs/recreational drugs including alcohol.
- I consent to random urine or oral drug screens, in addition to random pill counts. My failure to comply will result in immediate discharge from the practice. I understand that drug screen results can be given to my other healthcare provider, pharmacy, and law enforcement of judiciary body to release any pertinent information regarding my prescription or urine/blood screen results.
- I may be contacted any time between appointments and asked to present to the clinic for a pill count and/or drug screen. If I do not respond to the message(s) left by the staff or if I no longer have a working number, I understand I may be discharged from the clinic. If at any time I will be out of town and unreachable, I will notify the office in advance.

- Patient will be held accountable for any prescriptions written by Dr. Mark John. Any lost and stolen prescriptions **will not** be replaced. It is the patient's **responsibility** to notify ISRL of any misplaced medications or prescriptions.

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- Medication therapy usually is not the only part of the overall treatment plan. I agree to comply with all other treatments as outlined by Dr. Mark John which may include, but are not limited to: physical therapy, imaging studies (MRI, CT scan, X-ray), psychological counseling/evaluations as orders. My failure to follow the treatment plan as outlined by Dr. Mark John, suggests that I no longer agree with the treatment plan and may result in being discharged from the practice.

**** If I refuse to sign the treatment plan, I understand I MAY NOT be treated at Interventional Spine & Rehabilitation of Louisiana.**

Dr. Mark John may terminate this agreement at any time if he has cause to believe that I am not complying with the terms of this agreement. The patient may terminate this agreement at any time. If this agreement is terminated, the doctor/patient relationship is terminated and the patient will be formally discharged from the facility.

I agree a photocopy of this agreement shall be as valid as the original.

I hereby authorize Dr. Mark John to disclose any and all of the information in my records to any person, corporation or agency in which is or may be liable for all or part of ISRL charges or who may responsible for determining the necessity, appropriateness, amount or other matter to the health maintenance organizations, preferred provider organizations, worker's compensation carriers, welfare funds, the social security administration or its intermediaries or carries. I understand that my medical records may contain information that indicates that I may have a communicable disease, which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus (HIV), also known as acquired immune deficiency syndrome (AIDS). With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning my identity and release ISRL, its agents and its employees from liability in connection with the release of information contained therein.

I, the undersigned, attest that the above agreement was discussed with me, and I fully understand and agree to ALL of the conditions, requirements, and instructions. I also understand that failure to comply with the above may result in discharge from the practice.

Patient/Guardian Signature: _____ Date: _____

Printed Name: _____

*** Bring ALL your medications (prescription, over the counter, vitamins, etc.) to EVERY appointment.