SAMPLE
INFORMED CONSENT FORM

Introduction

This sample informed consent form can be used with patients who are beginning long-term therapy with opioid analgesics to help ensure they understand the side effects, risks, conditions, and purpose of their treatment. This document can help facilitate clear communication between patients and healthcare providers about long-term opioid therapy, clearly define treatment expectations, and resolve any questions or concerns patients may have before treatment initiation.

Opioid Therapy for Chronic Pain: Sample Informed Consent*

Please review the information listed here and put your initials next to each item when you have reviewed it with your provider and feel you understand and accept what each statement says.

_____My provider is prescribing opioid pain medications for the following conditions(s):

_____

_____When I take these medications, I may experience certain reactions or side effects that could be dangerous, including 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 will become physically dependent on them, meaning that my body will become 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 abdominal pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny 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 medications 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 medicines 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 medicines.

*Adapted from the American Academy of Pain Medicine
http://www.painmed.org/Workarea/DownloadAsset.aspx?id=3211

_____I have discussed the possible risks and benefits of taking opioid medications for my condition with my provider and have discussed the possibility of other treatments that do not use opioid medications, including:

_____

_____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 will 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, and meet other goals that I have discussed with my provider, but if these medications do not help me meet those goals, they will be stopped.

_____**For Men**: Taking opioid pain medications chronically may cause low testosterone levels and affect sexual function.

_____**For Women**: It is my responsibility to tell my provider immediately if I think I am pregnant or if I am thinking about getting pregnant. If I become pregnant while taking these medications and continue to take the medicines 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 my provider 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
_____	_____	_____
Provider signature	Provider name printed	Date

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