Department of Veterans Affairs

Consent for Long-Term Opioid Therapy for Pain

A. IDENTIFICATION

1. Patient Name, Social Security Number, and Date of Birth:

Name: Last, First, Middle	Social Security Number	Date of Birth

2. Decision-making capacity:

☐ The patient HAS decision-making capacity (skip to item 3).

☐ The patient DOES NOT HAVE decision-making capacity. Enter surrogate name and relationship to the patient. (If the patient's surrogate is not established or available, refer to Handbook 1004.01 for guidance).

Name: Last, First, Middle	Relationship

3. Name of the treatment: Long-Term Opioid Therapy for Pain

4. Practitioner obtaining consent:

Name: Last, First, Middle

5. Supervising practitioner: (if applicable)

Name: Last, First, Middle

6. Additional practitioner(s) performing or supervising the treatment: (if not listed above)

B. INFORMATION ABOUT THE TREATMENT

7. Reason for long-term opioid therapy (diagnosis, condition, or indication):

8. Location of pain:

9. Goal(s) of long-term opioid therapy (e.g., pain score, functional abilities such as go back to work, climb stairs, walk short distances, sleep through the night, do daily household chores, start a light exercise program):

10. Name of current or initial opioid medication(s):

11. Brief description of the treatment:

Opioids are very strong medicines that may be used to treat pain. You may already be taking opioids. Or your provider may try to give you opioids to find out if they will help you. They may try them for a short time or continue them for the rest of your life. Your provider will learn more about your risks and side effects when you are trying the opioids. If the risks and side effects outweigh the benefits, your provider will stop the prescription.

If your provider continues your opioid prescription, the goals of your treatment may change over time. The names and doses of your opioids may also change. You will not need to sign another consent form for these changes. You may be asked to sign another consent form if you seek opioid pain care from another VA provider.

Your provider will monitor your prescription. This may include checking how often you refill and renew your prescription, counting pills, asking you about your symptoms, and testing your urine, saliva, and blood. If you do not take opioids responsibly, your provider may stop your prescription. For example, if you do not let your provider monitor how you are responding to the opioids or tell them if you are taking other drugs that may affect the safety or effectiveness of your opioid treatment, your provider may stop the prescription.

For your safety, your provider and pharmacist will monitor when you renew and refill your opioids within VA. Consistent with state law, they will also monitor this outside of VA. Most states have monitoring programs that track unsafe patterns of prescription drug use. VA and these programs may obtain and share information about you without your specific consent.

Your provider will review with you a Patient Information Guide called "Taking Opioids Responsibly" to make sure that you know how to take your medication safely. You will be given a copy of the guide so that you can use it as a reference

12. Potential benefits of the treatment:

Opioids -- when added to other treatments as part of your pain care plan -- may reduce your pain enough for you to feel better and do more. It is unlikely that opioids will eliminate your pain completely. It is possible that you may not receive any benefits from opioid therapy.

13. Known risks and side effects of the treatment:

Possible opioid side effects include:

- Sleepiness or "slow thinking"
- Mental confusion, bad dreams, or hallucinations
- Constipation
- Intestinal blockage
- Itching
- Sweating
- Nausea or vomiting
- Decreased sex hormones
- Irregular or no menstrual periods
- Depression
- Dry mouth that causes tooth decay
- Allergies

Other risks of opioid therapy:

- Withdrawal symptoms if you suddenly stop taking opioids, lower the dose of your opioids too quickly, or take a drug that reverses the effects of your opioids. Withdrawal symptoms are caused by physical dependence that is a normal result of long-term opioid therapy. Some common withdrawal symptoms are runny nose, chills, body aches, diarrhea, sweating, nervousness, nausea, vomiting, mental distress, and trouble sleeping.
- Sleep apnea (abnormal breathing pauses during sleep)
- Worsening of pain
- Impaired driving or impaired ability to safely operate machinery
- Tolerance, which means that you may need a higher dose of opioid to get the same pain relief, resulting in an increase in the likelihood of the other side effects and risks
- Addiction (craving for a substance that gets out of control). Some patients become addicted to opioids even when they take opioids as prescribed.
- Drug interactions (problems when drugs are taken together). Taking small amounts of alcohol, some over-the counter medications, some herbal remedies, and other prescription medications can increase the chance of opioid side effects.
- Risks in pregnancy:
  - *Continued use of opioids during pregnancy can cause your baby to have withdrawal symptoms after birth and require your baby to stay in the hospital longer after birth.
  - *Stopping opioids suddenly if you are pregnant and physically dependent on opioids can lead to complications during pregnancy.
  - *Studies have not shown a clear risk for birth defects with opioid use in pregnancy. If there is an increased risk for birth defects in pregnancy with opioid use, it is likely small.
- Death

14. Alternatives to the treatment:

You have the option not to take opioids. Other treatments can be used as part of your pain care plan. Alternatives include:

- Heat and cold therapy (heating pads, ice packs)
- Stretching
- Exercise
- Weight loss
- Massage
- Acupuncture
- Chiropractic
- Nerve Stimulation
- Relaxation or stress reduction training
- Physical therapy
- Occupational therapy
- Mental health treatment
- Self-care techniques
- Counseling and coaching
- Meditation
- Rehabilitation
- Non-opioid pain medicines (Non-steroidal anti-inflammatory drugs, antidepressants, anticonvulsants)
- Injections
- Specialist pain care
- Surgery
- Pain classes
- Support groups
- Attention to proper sleep

15. Additional Information:

16. Comments:

C. SIGNATURES

Practitioner obtaining consent:

- All relevant aspects of the treatment and its alternatives (including no treatment) have been discussed with the patient (or surrogate) in language that s/he could understand. This discussion included the nature, indications, benefits, risks, side effects, monitoring, and likelihood of success of each alternative that was considered.
- I have discussed all of the information contained in the education document "Taking Opioids Responsibly" with the patient (or surrogate).
- The patient (or surrogate) demonstrated comprehension of the discussion.
- I have given the patient (or surrogate) an opportunity to ask questions.
- I did not use threats, inducements, misleading information, or make any attempt to coerce the patient/surrogate to consent to this treatment.
- I have offered the patient (or surrogate) the opportunity to review and receive a printed copy of the consent form.
- If the patient is a woman of childbearing age (ages 15-50), I have discussed the patient's pregnancy status and pregnancy intentions.
  - * If the patient is not considering pregnancy, I have discussed (or referred the patient for) contraceptive counseling.
  - * If the patient is considering pregnancy, I have discussed (or referred the patient for) preconception counseling.

Signature	Date	Time

Patient or surrogate:

- I understand that to receive long-term opioids I must agree to my opioid treatment plan by signing this consent form.
- Someone has explained the treatment, what it is for, and how it could help me.
- Someone has explained things that could go wrong, including serious side effects and death, particularly if I do not take my medicine as prescribed.
- Someone has told me about other treatments that might be done instead, and what would happen if I have no treatment.
- I have discussed the information in the document "Taking Opioids Responsibly" with my provider.
- I understand the importance of:
  - * telling my provider about side effects.
  - * telling my provider about changes in my pain and daily function.
  - * getting my opioids from only my VA provider and no one else.
  - * not giving away (or selling) my opioids to other people.
  - * storing my opioids in a safe place away from children, family, friends, and pets.
  - * safely getting rid of opioids I do not need.
  - * not drinking alcohol or taking illegal street drugs when I am on opioids.
  - * for women, telling my provider if I think I might be pregnant, know I am pregnant, or am planning to become pregnant.

- I plan to use my medications responsibly, and take them as prescribed.
- I understand how to refill my opioid prescription or get a new prescription. I understand that my VA pharmacy may be closed on weekends, holidays, and after regular clinic hours. I understand that my provider might not give me early medication refills or replace doses that are lost or stolen.
- I understand that my provider may order urine or blood drug tests with my consent (separate from this consent). I understand that the results of these tests or my refusal to be tested may cause my provider to talk to me about changing my opioid treatment plan.
- I understand that I may have to stop opioids if my provider thinks that it is unsafe for me to continue.
- Someone has answered all my questions.
- Someone has given me information about how to contact the clinic, if there is a problem and who to call in an emergency.
- I know I may refuse or change my mind about having treatment. If I do refuse or change my mind, I will not lose my health care or any other VA benefits.
- I have been offered the opportunity to review and receive a copy of my consent form.
- I choose to have this treatment.

Signature | Date | Time

Witnesses: No witness is required if the patient or surrogate signs their name. Two witnesses are required only when the patient's signature is indicated with an "X" or some other identifying mark.

Witness Name (Please Print)

Witness Signature | Date | Time

Witness Name (Please Print)

Witness Signature | Date | Time