



Indian Society for
Study of Pain

ISSP TREATMENT CONSENT FOR OPIOIDS AND CONTROLLED DRUGS

Document No :
ISSP/Controlled drugs
consent/2018

Applicable: All over India

INFORMED CONSENT AND AGREEMENT FOR OPIOIDS USAGE

NAME OF PATIENT: _____ DATE: _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended opioid drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved, recommended to you by me, as your treating doctor. For the purpose of this agreement the use of the word "treating doctor" is defined to include not only my treating doctor but also my treating doctor's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my treating doctor to treat my condition which has been explained to me as chronic malignant pain. I hereby authorize and give my voluntary consent for my physician to administer or prescribe opioids.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or rarely addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me.

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatments and as & when necessary.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s) , physical and emotional dependence or rarely even addiction. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) / treatment (s) for the treatment of my chronic malignant pain.

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The goal of this treatment is to help me gain control of my chronic malignant pain in order to live a more productive and active life. I realize that I have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) / treatment (s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s).

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

That this pain management plan relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers') for chronic malignant pain prescribed by my physician. Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the medication(s) may be discontinued.
- I will disclose to my physician all medication(s) that I take at any time, prescribed by any physician.
- I will use the medication(s) exactly as directed by my physician.
- I agree not to share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will not allow or assist in the misuse/diversion of my medication; nor will I give or sell them to anyone else.
- I understand that my medication(s) will be refilled on a regular basis.

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- Refill(s) will not be ordered before the scheduled refill date. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) only from ONE physician unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then my physician may try alternative medication(s) or may taper me off all medication(s). I will not hold my physician liable for problems caused by the discontinuance of medication(s).
- I recognize that my chronic malignant pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program recommended by my physician to achieve increased function and improved quality of life.
- I agree that I shall inform any doctor who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. Any unauthorized increase in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must keep all follow-up appointments as recommended by my physician or my treatment may be discontinued.

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I certify and agree to the following:

- 1) I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.
- 2) I have never been involved in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)
- 3) No guarantee or assurance has been made as to the results that may be obtained from chronic malignant pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic malignant pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.
- 4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic malignant pain. I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.

Patient Name & Signature

Witness & Relation with the patient Name & Signature

Doctor's Name & Signature (or Appropriately Authorized Assistant)

Date

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Special interest group (SIG) has been formed by ISSP and the committee comprises of:

- a) Chairman: Dr Pankaj N Surange
- b) Vice Chair: Dr Rajeev Harshe
- c) Members:
 - a. Dr Anurag Agarwal
 - b. Dr Gaurav Goyal
 - c. Dr Pavan Kumar Bichal
 - d. Dr Manish Raj
 - e. Dr Nazir Ahmad
 - f. Dr Sweta Salgaonkar
 - g. Dr Rohit Lahori
 - h. Dr Ashish Chakraborty

