

**PLEASE BE ADVISED, WE  
WILL NO LONGER BE  
PROVIDING CHRONIC  
NARCOTIC PAIN  
MANAGEMENT SERVICES.  
INFORM US IF THIS IS THE  
PURPOSE OF YOUR VISIT  
SO WE MAY REFER YOU  
TO THE APPROPRIATE  
PAIN MANAGEMENT  
SPECIALIST.**

**Patient signature:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# PROBLEM LIST

Name: \_\_\_\_\_ D.O. B: \_\_\_\_\_

<b>Allergies to Medication:</b>  <b>REACTIONS:</b>	Does <b>PATIENT HAVE</b> Advanced Directive: <div style="text-align: center; font-size: 1.2em;"><b>Y   N</b></div> If yes, copy must be provided to the office.
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Family History:	Significant for:	Other Physicians:
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Chronic Problems	Date Resolved	Temporary Problems	Date Resolved	Surgeries	Date
				Hospitalizations	Date

TESTS	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE
Cardiac Profile								
Colon/Rectal Exam								
Complete Exam								
Lipid Profile								
Mammogram/Base								
Pap Test								
Prostate/PSA								
Stool Blood								
TB								
MMR								
Tetanus/TD								
Varicella								
Pneumonia/Yearly Flu								
Vision/Glaucoma								
X-Ray/EKG								
Other:								

<b>Tobacco Use:</b> Yes No  _____ Packs/Day _____ Years _____ Quit _____ Years	<b>Alcohol Use:</b> Yes No  _____ Beer _____ oz./week _____ Wine _____ oz./week _____ Liquor _____ oz./week	<b>Drug Use:</b> Yes No  Type _____ How often _____ Quit _____ Years _____
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# Family Medical History

Health problems sometimes run in the family. That's why it's important to know as much as you can about the health of your birth family. This information can help your doctor provide better care.

Start with what you know, then ask your parents or other relatives for more information. It's a good idea to update this chart every year or so. Take a copy with you every time you see a new doctor so that he or she can keep it in your chart.

Patient Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Family Member	Name	Health problems (and approximate age when problem started or occurred)	If no longer living, cause of death (and age at death)
My mother			
My father			
My sisters and brothers			

Date: \_\_\_\_\_

# Wolfson Medical Center

## PATIENT INFORMATION

Patient name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

City, State, Zip code: \_\_\_\_\_ Social Sec # \_\_\_\_\_

(If minor please provide parents)

Email address for billing purpose: \_\_\_\_\_

**SEX:** [MALE] [FEMALE] **STATUS:** [MARRIED] [SINGLE] [WIDOWED] [OTHER]

Reason for your visit \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Referred by: \_\_\_\_\_

### EMPLOYER INFORMATION

[EMPLOYED] [UNEMPLOYED] [FULL-TIME STUDENT] [RETIRED]

(If minor provide parents)

Employer Name: \_\_\_\_\_

Employer Address and phone number: \_\_\_\_\_

### INSURANCE INFORMATION

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Insured Name: \_\_\_\_\_

ID #: \_\_\_\_\_ ID #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

### EMERGENCY INFORMATION

Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Daytime Number: \_\_\_\_\_ Nighttime number: \_\_\_\_\_

I hereby guarantee payment for the entire balance of the above-named patient. I assign and authorize payment of medical benefits directly to Wolfson Medical Center and his representatives. I authorize release of any information requested by insurance companies or government agencies about this assignment, I have read, understand, and agree to the financial policies and various releases and guarantees.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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# Wolfson Medical Center

## MEDICATION INFORMATION

**PATIENT NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

\_\_\_\_\_

### CURRENT MEDICATION

Name	Strength	Frequency	Quantity

Updated by: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
--

**PHARMACY YOU WOULD LIKE US TO HAVE ON FILE FOR MEDICATION TO BE CALLED IN.**

**PHARMACY NAME:** \_\_\_\_\_

**PHARMACY PHONE:** \_\_\_\_\_

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# Advanced Directives

Adults 18 years and older have the right to make decisions regarding their own health care. They may accept or refuse care based on their own desires. The best time to determine what will be regarding the choice of health care is before admitted to a health care facility. In the event a person loses the ability to make these decisions, there are two legal documents that protect their right to refuse unwanted medical treatment, or to request treatment that is wanted. These documents are called Advanced Directives.

There are two forms of Advanced Directives that are acknowledged in Nevada.

## 1. Declaration (Living Will) NRS 449.535-449.720

The Declaration (Living Will) is in effect only when the attending physician determines the patient's condition is terminal and there is no chance for recovery. The Declaration (Living Will) allows a person to state his or her own medical decisions.

## 2. Durable Power of Attorney NRS 449.800-449.860

The Durable Power of Attorney for Health Care allows a person to name someone else to make the decisions about their medical care, including decisions about life support, if they can no longer speak for themselves. This appointed person may make decisions regarding health care if a condition renders the patient unable to speak; it does not require the condition to be terminal.

In the case that a person has not prepared an Advanced Directive, the closest living relative would be asked to give consents and make decisions for the health care given.

For more information regarding Advanced Directives or to ask questions, you may contact the following resources:

Department of Human Resources  
Health Divisions  
Bureau of Licensure and Certification  
4220 South Maryland Parkway, #810  
Las Vegas, NV 89119 702 486-6515

Choice in Dying  
1620 Eye Street N.W., #202  
Washington D.C 20006  
1 800-989-9455

Because the Durable Power of Attorney for HealthCare Decisions is legal document, you may want to contact the following for a referral to an attorney.

State Bar of Nevada  
600 East Charleston Blvd.  
Las Vegas, NV 89104 702 382-2200

State Bar of Nevada  
1325 Airmotive Way, #140  
Reno, NV 89502 775 329-4104

\*\*\*Providers of service are required to inform their patients of their right to formulate an Advanced Directive, prior rendering medical treatment that requires a consent form and to document in the enrollee's medical record whether an Advanced Directive has been executed.

**I have an Advanced Directive**       **Yes** *IF YES, please provide copy to office.*       **No**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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# Wolfson Medical Center

6803 W. Tropicana Ave  2655 Box Canyon Dr.  921 S. Las Vegas Blvd  
Las Vegas NV 89103 Las Vegas, NV 89128 Las Vegas, NV 89101  
Phone (702) 452-2525 (702) 363-9900 (702) 910-2100  
Fax (702) 452-2534 (702) 363-9995 (702) 910-2105

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**STAT PATIENT IN OFFICE NOW**

Patient Name: \_\_\_\_\_

SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

.....

I HEREBY AUTHORIZE THE RELEASE OF RECORDS FROM: \_\_\_\_\_

Please provide contact information for provider. Failure to do so will delay the process in obtaining medical records.

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

TO RELEASE RECORDS TO: \_\_\_\_\_

Please provide contact information for provider. Failure to do so will delay the process in obtaining medical records.

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

.....

(Check all applicable): All Records      Laboratory/Pathology Records      X-Ray/Radiology Records  
Abstract/Summary      Pharmacy Records      Other: \_\_\_\_\_

.....

Please initial if you wish any of the following not to be released.

Do not release information related to:

\_\_\_ Substance Abuse      \_\_\_ Psychiatric/ Mental Health      \_\_\_ HIV      \_\_\_ Other: \_\_\_\_\_

.....

The information may be used/disclosed for the following purpose:

To continue care      For health insurance      Other: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Printed Name

Date

This authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional time. If records being to patient, there is a charge of .60 cents per page. **A copy of this paperwork is the same value of its original.**

# MEDICAL HISTORY SHEET

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Allergies to medication? [YES] [NO]

If yes, list name of medication and description of reaction \_\_\_\_\_

## CURRENT MEDICAL HISTORY

Patient medical history:

Cancer	Stroke	Thyroid	Emphysema	Asthma
Diabetes	Seizure	Kidney Problems	Aneurysm	Osteoporosis
Anemia	Heart Attacks	Lupus	Rheumatoid Arthritis	High Cholesterol
Hypertension	Heart Failure	Psychiatric Disorder	Neurological Disorder	

## SOCIAL HISTORY

Do you currently smoke? [YES] [NO]  
If yes, how long? \_\_\_\_\_, How much? \_\_\_\_\_

If no, have you ever smoked? [YES] [NO]  
If yes, how long? \_\_\_\_\_, How much? \_\_\_\_\_

Do you consume alcohol? [YES] [NO] If yes, how many drinks per day? \_\_\_\_\_

Do you consume **caffeine**? [YES] [NO] COFFEE? [YES] [NO] SODA? [YES] [NO]

Do you exercise? [YES] [NO] If yes, what type of exercise? \_\_\_\_\_ How often? \_\_\_\_\_

Occupations: PRESENT \_\_\_\_\_ PAST \_\_\_\_\_

## MEDICAL HISTORY

Surgeries and approximate dates: \_\_\_\_\_

Hospitalizations (Other than for surgery) \_\_\_\_\_

## HEALTH SCREENING

When did you last have:

EKG \_\_\_\_\_  
Chest X-ray \_\_\_\_\_  
Mammogram \_\_\_\_\_  
Breast Exam \_\_\_\_\_  
Rectal Exam \_\_\_\_\_  
TB Skin Test \_\_\_\_\_  
Screening cholesterol \_\_\_\_\_

Immunizations?

Hepatitis \_\_\_\_\_  
Diphtheria \_\_\_\_\_  
Polio \_\_\_\_\_  
MMR (Measles, Mumps, Rubella) \_\_\_\_\_  
Pneumonia shot \_\_\_\_\_  
Flu (influenza) shot \_\_\_\_\_  
Tetanus \_\_\_\_\_

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**For the following, mark whether you have ANY of the following**

			<b>symptoms:</b>					
<u>EYES</u>	YES	NO	<u>HEART</u>	YES	NO	<u>BLOOD</u>	YES	NO
Cataracts	_____	_____	Aching in mid-chest	_____	_____	Anemia	_____	_____
Pain in eyes	_____	_____	Skipping beats	_____	_____	Very easy bruising	_____	_____
Double vision	_____	_____	Shortness of breath	_____	_____	Bleeding disorder	_____	_____
Sudden vision loss	_____	_____	Fainting spells	_____	_____	Lumps under arms	_____	_____
Glaucoma	_____	_____	Heart murmur	_____	_____	/groin	_____	_____
<b><u>EARS</u></b>			Swelling of ankles	_____	_____	<b><u>ENDOCRINE</u></b>		
Pain	_____	_____	High blood pressure	_____	_____	Thyroid trouble	_____	_____
Bleeding	_____	_____	# Of years	_____	_____	Intolerance to cold/	_____	_____
Buzzing	_____	_____	Heart attack	_____	_____	Heat	_____	_____
Dizziness	_____	_____	How many?	_____	_____	Diabetes	_____	_____
Loss of hearing	_____	_____	When?	_____	_____	Excessive thirst	_____	_____
Earaches	_____	_____	<b><u>GASTROINTESTINAL</u></b>			Loss of sex drive/	_____	_____
<b><u>NOSE AND THROAT</u></b>			Stomach pains/	_____	_____	Erection ability	_____	_____
Hoarseness	_____	_____	Indigestion	_____	_____	<b><u>PSYCHIATRIC</u></b>		
Pain	_____	_____	Heart burn	_____	_____	Depression	_____	_____
Bleeding	_____	_____	Constipation	_____	_____	Anxiety attacks	_____	_____
Stuffy nose	_____	_____	Recent changes	_____	_____	<b><u>BREASTS</u></b>		
Trouble swallowing	_____	_____	In Bowel habits	_____	_____	Tenderness around	_____	_____
<b><u>MUSCULOSKETAL</u></b>			Vomiting of blood	_____	_____	Periods	_____	_____
Morning Joint Stiffness	_____	_____	Ulcers	_____	_____	Discharge from	_____	_____
Swelling/Arching	_____	_____	Loss of appetite	_____	_____	Nipples	_____	_____
Joints	_____	_____	Chronic diarrhea	_____	_____	Blood from nipples	_____	_____
Severe backaches	_____	_____	Black, tarry stool	_____	_____	Lump in breast	_____	_____
<b><u>NERVOUS SYSTEM</u></b>			Bright, red blood	_____	_____	Cancer	_____	_____
Seizure/Convulsions	_____	_____	By rectum	_____	_____	<b><u>GYNECOLOGICAL</u></b>		
Fainting Spells	_____	_____	Rectal pain	_____	_____	Date of last pap smear	_____	_____
Stroke	_____	_____	Swelling of abdomen	_____	_____	Date of last period	_____	_____
Paralysis/Weakness of limb	_____	_____	Jaundice	_____	_____	Date of menopause	_____	_____
Increasing trouble w/ Memory	_____	_____	Tea-colored Urine	_____	_____	Bleeding since	_____	_____
Getting lost easily	_____	_____	<b><u>URINARY</u></b>			Menopause	_____	_____
Hallucinations	_____	_____	Burning on urination	_____	_____	Discharge	_____	_____
Tingling in a limb	_____	_____	Bloody urine	_____	_____	Excessive bleeding	_____	_____
Numbness in any	_____	_____	Frequent urination	_____	_____	W/ periods	_____	_____
Part of the body	_____	_____	Difficulty in getting	_____	_____	Dilation & curettage	_____	_____
Shaking of a limb	_____	_____	Urination started	_____	_____	(D&C)	_____	_____
Staggering	_____	_____	Backaches	_____	_____	Venereal disease	_____	_____
Migraine Headache	_____	_____	Losing urine control W/	_____	_____	<b><u>OBSTETRICS</u></b>		
Inability to speak	_____	_____	Coughing/sneezing	_____	_____	# Of pregnancies	_____	_____
<b><u>CHEST</u></b>			Kidney stone	_____	_____	# Of live births	_____	_____
Coughing of blood	_____	_____	<b><u>HEAD AND NECK</u></b>			# Of miscarriages	_____	_____
Pleurisy /Pneumonia	_____	_____	Stiff neck	_____	_____	# Of stillborn	_____	_____
Clots on lungs	_____	_____	Severe or frequent	_____	_____	# Of therapeutic	_____	_____
Tuberculosis	_____	_____	Headaches	_____	_____	Abortions	_____	_____
Wheezing or Asthma	_____	_____	<b><u>SKIN</u></b>					
			Hives / Shingles	_____	_____			
			Ulcers /Frequent boils	_____	_____			
			Recurrent itching	_____	_____			

# Office Policies

**PLEASE READ AND SIGN ALL, IT MAY NOT APPLY BUT THESE ARE THE OFFICE POLICIES.**  
**PATIENT RESPONSIBILITY:**

*It is your responsibility to follow up on any lab or test results (i.e. mammogram, x-ray, blood work, etc.) If you know you obtaining any tests, please make a follow up appointment at the time of check out.* If we are waiting for insurance approval, please make an appointment with us after the test has been approved by the insurance company. **I understand that effective April 30, 2014 there will be a \$50.00 cancellation fee when scheduled appointments are not cancelled 24 hours prior. To avoid any fees please cancel any appointments 1 business day prior.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **PATIENT POLICY:**

Payment is due in full at the time of service. We do bill most insurance company as courtesy to you, but you are ultimately responsible for all charge incurred if your insurance company should choose not to pay. Deductible, co-pay, and co-insurance are due at the time of service. **WE DO NOT ACCEPT CHECKS, NO EXCEPTIONS!!**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **ASSIGNMENT OF BENEFITS:**

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to, including Medicare, Private Insurance Companies, and any other health plan to WMC. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether insurance company pays them. I hereby authorize said assignee to release all information necessary to secure payment. I understand that my medical insurance carrier may not cover some services and, that I may be responsible for payment of charges. I hereby authorize the release of any medical or billing information (including medical records) by Wolfson Medical Center to my referring doctor, insurance company, or responsible party.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **MEDICATION ADMINISTRATION:**

**I am aware that the medical assistants administer the injections, medication, nebulizer treatments, and TB skin tests.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **TO ALL SUBOXONE PATIENTS:**

**THE SUBOXONE TREATMENT** will not be billed to any insurance. The office visit must be paid in full at time of service. Any re-imburement from insurance will not be accepted.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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# Acknowledgement of receipt of privacy practice

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

During providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The **Notice of Privacy Practices** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our **Notice of Privacy Practices**, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional.

Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our **Notice of Privacy Practices**. Our **Notice of Privacy Practices** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our **Notice of Privacy Practices**.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or healthcare operations, but as described in our **Notice of Privacy Practices**, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our **Notice of Privacy Practices** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from WMC. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of federal Regulations.

## Patient Record of Disclosures

I wish to be contacted in the following manner (Check all that applies).

- Home Telephone: \_\_\_\_\_  
 OK to leave a detailed message  Leave message with only call back number
- Work Telephone: \_\_\_\_\_  
 OK to leave a detailed message  Leave message with only call back number
- Written Communication:  
 OK to mail to home address  OK to fax to \_\_\_\_\_

## Record of disclosures of protected health information

NAME	RELATIONSHIP	PHONE #

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*PLEASE NOTE: Uses and disclosures for TPO (Treatment/Payment/Healthcare Operations) may be permitted without prior Consent in the case of an emergency.*

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# Controlled Substances Agreement

**PLEASE BE ADVISED, WE WILL NO LONGER BE PROVIDING CHRONIC NARCOTIC PAIN MANAGEMENT SERVICES. INFORM US IF THIS IS THE PURPOSE OF YOUR VISIT SO WE MAY REFER YOU TO THE APPROPRIATE PAIN MANAGEMENT SPECIALIST.**

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you. The long-term/ short term use of such substances as opioids (narcotic analgesics), benzodiazepine, tranquilizers, and barbiturate sedatives are controversial because of uncertainty regarding the extent to which they provide long-term benefit.

There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged.

For this reason, the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)
2. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
3. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.
4. You may not share, sell, or otherwise permit others to have access to these medications.
5. Unannounced, random urine or serum toxicology screens may be requested, this will be at the patient's expense and your cooperation is required. Presence of unauthorized substances may be subject to discontinuation of medication and/or termination from care effective immediately.
6. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.
7. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
8. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.
9. Early refills will generally not be given.
10. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived, and these authorities may be given full access to our records of controlled substances administration.
11. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.
12. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.
13. The risks and potential benefits of these therapies are explained elsewhere [and you acknowledge that you have received such explanation].

You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all its terms.

---

Patient Name (Printed)

Patient Signature

Date

*Approved by the AAPM Executive Committee on April 2, 2001.  
© 2001 American Academy of Pain Medicine*

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# Consent for Suboxone / Subutex Therapy

**Suboxone is used to treat opiate addiction.**

**Subutex is a prescription medication that's used to treat narcotic addictions and dependence.**

This decision was made because my condition is serious or other treatments have not helped my pain. I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction, and possibility that the medicine will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. I will tell my doctor about all other medicines and treatments that I am receiving. **DURING MY TREATMENT WITH DR. WOLFSON I WILL NOT OBTAIN TREATMENT FROM ANOTHER PHYSICIAN FOR OPIOID DEPENDENCE.**

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for him or herself.

I am aware that certain other medicines such as nalbuphine (Nubain™), pentazocine (Talwin™), buprenorphine (Buprenex™), and butorphanol (Stadol™), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is different from addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped, or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

**(Males only)** I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire, and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

**(Females Only)** If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines; the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

**I understand I am expected to follow up with Dr. Wolfson until treatment is complete. Monthly office contact must be made either in person or over the phone to justify continuation in treatment.**

**If I do not follow up within 30 days after my last office visit it will be assumed, I have successfully completed the treatment. Wolfson medical center will not accept a returning Suboxone patient if he/she does not follow up within the 30-day period allowed. I am aware I will be randomly drug tested at patient's expense. NO EXCEPTIONS!!**

**I have read this form, or have it read to me. I understand all of it. I have had a chance to have all my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines.**

**Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_**

*Approved by the AAPM Executive Committee on January 14, 1999.  
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**A copy of this paperwork is the same value of its original.**