

OKLAHOMA

**Guidelines for Prescription of
Opioid Medications for Acute and Chronic Pain**

*Developed and Adopted
by the*
Physician Advisory Committee

**Adopted by the Administrator
of the
Oklahoma Workers' Compensation Court**

Effective April 1, 2007
Revised effective November 1, 2007

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INTRODUCTION: The Physician Advisory Committee (PAC), a statutorily created advisory body to the Oklahoma Workers' Compensation Court, has been directed by Oklahoma Statute to develop and adopt treatment guidelines for injured Oklahoma workers for adoption by the Administrator of the Workers' Compensation Court. The PAC is composed of nine members; three appointed by the Governor, three appointed by the President Pro Tempore of the State Senate, and three appointed by the Speaker of the Oklahoma House of Representatives. By statute, the Governor's appointees must include a doctor of medicine and surgery, a family practitioner in a rural community of the state, and an osteopathic physician; the President Pro Tempore's appointees must include a doctor of medicine and surgery, a doctor of medicine or an osteopathic physician engaged in the practice of occupational medicine, and a podiatric physician; and the Speaker's appointees must include an osteopathic physician, a doctor of medicine or an osteopathic physician, and a chiropractic physician.

OBJECTIVE: The objective of these Prescription Guidelines is to provide standards for prompt, reasonable and appropriate treatment for acute and chronic pain associated with work place injuries and to expedite optimum recovery and return to work. The long-term use of prescription opioid medications for chronic pain may be a factor in the development of long-term disability and therefore must be monitored carefully to avoid this problem. This condition may be preventable if at-risk patients and practices are proactively identified and managed appropriately.

DEVELOPMENT OF THE GUIDELINES: The Physician Advisory Committee (PAC) developed these guidelines. Input was received from a wide variety of sources including employers, insurance carriers, and health care providers. Appropriate scientific literature and statutory provisions (including Title 63, Oklahoma Statutes, Section 2-551) and rules and policies of the Oklahoma State Board of Medical Licensure and Supervision were reviewed, together with the Occupational Medicine Practice Guidelines promulgated by the American College of Occupational and Environmental Medicine, the Official Disability Guidelines published by the Work Loss Data Institute, and practice parameters of the various specialty societies (The American Academy of Pain Medicine, International Association for the Study of Pain, and American Pain Society). Treatment protocols from Colorado, Minnesota and Washington were also utilized.

APPLICATION: This treatment guideline should not be construed as including all proper methods of care or excluding other acceptable methods of care which are based upon nationally accepted practice standards.

For injury or illness treated under the Oklahoma Workers' Compensation Act, compliance with this treatment guideline is mandatory and an employer or insurer for an employer is not required

to pay for treatment which is not in compliance with the treatment guidelines, unless prior authorization is received. If prior authorization is refused, independent review may be obtained under court procedures.

Authorization for treatment may not be denied on the sole basis the treatment is not addressed by this guideline if it is documented to be based upon nationally accepted practice standards.

This guideline does not affect any determination of liability for an injury under the Oklahoma Workers' Compensation Act, 85 O.S., Section 1, seq., and is not intended to expand or restrict a health care provider's scope of practice under any other statute.

I. TERMINOLOGY

- A. Abuse: Overuse in cases of celebration, stress, anxiety, despair, ignorance or self-medication.
- B. Acute pain: An essential biologic signal of the potential for or the extent of injury. It is usually short-lived and it generally disappears with healing.
- C. Addiction: A disease process involving use of psychoactive substances wherein there is a loss of control, compulsive use, and continued use despite adverse social, physical, psychological, or spiritual consequences.
- D. Chronic Pain: Pain is usually considered chronic if it persists more than 3 to 6 months. For purposes of this guideline chronic pain is defined as pain that persists 2 to 4 months from the date of injury.
- E. Physical dependence: A physiologic state of adaptation to a specific psychoactive substance characterized by the emergence of a withdrawal syndrome during abstinence, which may be relieved in total or in part by re-administration of the substance. Physical dependence is not necessarily associated with addiction.
- F. Tolerance: State in which an increased dosage of a psychoactive substance is needed to produce a desired effect.

II. ACUTE VS. CHRONIC PAIN

Pain is a complex phenomenon that has been described as an experience rather than a sensation. The experience, and the way each patient manifests it, is the product of cultural factors; previous personal, family, and social experiences with injury and pain, the patient's general stress and anxiety level, family and social roles and support, expectations for recovery and financial support, and character structure and coping methods.

- A. Acute Pain: Acute pain characteristically is of recent onset with a relatively short duration, lasting no more than days or weeks. It is associated with hyperactivity of the sympathetic nervous system and may generate sympathetic responses such as anxiety, tachycardia, and elevated blood pressure as well as somatic and neuroendocrine responses. Acute pain generally fluctuates in intensity and with exacerbating events.
- B. Chronic pain: Chronic pain, on the other hand, is pain persisting for at least one month beyond the usual course of an acute illness or the time required for an injury to heal, pain associated with a chronic pathologic process, or pain recurring at intervals of months or years. Evidence supports the fact that over time persistent pain can result in peripheral and central nervous system changes that facilitate pain pathways and thus amplify the pain experience. These physiological changes are thought to

occur at the level of the nociceptors and dorsal horn of the spinal cord and brain. Chronic pain is typically accompanied by few autonomic responses. Patients with chronic pain are often preoccupied with somatic symptoms, sleep, appetite and libido disturbances. In patients with chronic pain, psychological reactions to the pain are very common and may become the major contributors to impaired functioning. These symptoms can include depression, sleep disorders, anxiety, helplessness, and avoidance behaviors.

- C. Management: The early diagnosis and management of pain is essential. Management strategies become significantly altered once pain becomes chronic and initiating timely pain management interventions is essential to prevent physiologic spinal cord and brain changes that propagate chronic pain. The most important consideration is that before pain becomes chronic, there is a therapeutic window for preventing chronic, centrally mediated pain. During this period, before the development of chronic pain, patients present with some or all of the chronic pain characteristics, but their pain is still related to tissue damage. It is well localized, rather than poorly localized, and is not yet compounded by the motivational, affective, cognitive, and behavioral overlay that is seen with most chronic pain syndromes.

III. USE OF OPIOID MEDICATIONS FOR ACUTE PAIN

The distinction between acute and chronic pain is particularly relevant in the selection of effective analgesia. Acute pain should be relieved promptly and effectively to prevent development of abnormal, self-perpetuating pain reflexes that ultimately lead to the development of chronic pain. The goals of pain management are to improve function and activities of daily living, normalize sympathetic arousal and change pain perception. Pharmacologic agents may be used in doses that are adequate to relieve symptoms, but that do not exceed the patient's needs. Drugs or immobilization that prevents appropriate physical activity can hamper recovery. Opioids are useful for patients with acute pain such as surgery, burn, or trauma. The goal of such treatment is to provide adequate and timely pain management to the patient. Side effects of opioids that are difficult to treat may occur and must be balanced against the benefits of pain relief.

- A. Treatment of Acute Pain from Traumatic Injuries or Surgery (Post-Discharge):
1. Schedule II drugs should be prescribed for no longer than 2 to 3 weeks.
 2. Schedule III and Schedule IV drugs should be prescribed for no longer than 6 to 8 weeks.
- B. Relative Contraindications: In both acute and chronic pain, extreme caution should be used in prescribing controlled substances for workers with one or more relative contraindications.
1. History of alcohol or other substance abuse.
 2. Active alcohol or other substance abuse.
 3. Borderline and/or antisocial personality disorders.
 4. Mood disorders (e.g., depression) or psychotic disorders.

Note: If special circumstances seem to warrant the use of these drugs in these types of patients, then a pain management referral or referral for psychosocial evaluation is indicated (See Section VI. Psychosocial Evaluation and Treatment).

- C. Contraindications: Opioids in combination with sedative-hypnotic medications are generally contraindicated:
 - 1. Benzodiazepines (except if used to treat spasticity or psychiatric disorder).
 - 2. Barbiturates (except if used to treat a seizure disorder).
- D. Use caution when prescribing:
 - 1. Acetaminophen in doses greater than 4 grams (including, for example, combinations of drugs that include both an opioid and acetaminophen).
 - 2. Nonopioid drugs concomitantly with combination opioids (e.g., Tylenol given with Percocet).
 - 3. Tramadol (Ultram) to patients at risk for seizures and/or who are also taking drugs which can precipitate seizures (e.g., SSRI and tricyclic antidepressants).
- E. Consultation or referral to a pain management specialist should be considered when any of the following conditions exist:
 - 1. Underlying tissue pathology is minimal or absent, and correlation between the structural derangement caused by the original injury and the severity of the impairment is not clear.
 - 2. Standard treatment measures have not been successful or are not indicated.
 - 3. History of current or prior substance abuse.

IV. USE OF OPIOID MEDICATIONS FOR CHRONIC PAIN

Chronic pain may develop after an acute injury episode and is defined as pain that persists 2 to 4 months from the date of injury. Opioid medications serve a role in the management of chronic pain. The goal of opioid medications in chronic pain should focus on improvement in function and activity level. Opioid analgesics can be useful in the treatment of patients with intractable noncancer pain, especially where efforts to remove the cause of pain or to treat it with other modalities have failed or were not fully successful. The pain of such patients may have a number of different etiologies and may require several modalities. In addition, the extent to which pain is associated with psychological, physical, and social impairment varies greatly.

- A. Assessment: Beyond 2 to 4 months of acute/subacute opioid use, the following assessment is required:
 - 1. Perform a baseline history and physical, including pain history and the impact of pain on the patient, a complete exam, review of previous diagnostic and therapeutic results and an assessment of co-existing conditions.
 - 2. Obtain relevant baseline clinical or laboratory studies and/or urine drug screen, up to three times a year on a random basis, and/or as indicated.
 - 3. Obtain a Psychosocial Evaluation (See Section VI. Psychosocial Evaluation and Treatment).
 - 4. Baseline pain and functional assessments should be documented. Function includes social, physical, psychological, and daily as well as work activities.
 - 5. Assess the worker's need for and ability to participate in a return-to-work program, for example, physical rehabilitation and vocational counseling.
 - 6. Assess likelihood the patient can be weaned from opioids in the event there is no improvement in pain and function.
 - 7. Decide whether you have the expertise to treat chronic pain. If not, make an appropriate referral.

- B. Documentation:
1. Treatment agreement: You and your patient must together sign a treatment agreement that outlines: the risks and benefits of opioid use, the conditions under which opioids will be prescribed, the physician's need to document overall improvement in function, and patient responsibilities.
 2. Informed Consent: Patients should especially be warned about potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness and tolerance. Also, they should be warned about the possible danger associated with the use of opioids while operating heavy equipment or driving.
- C. Principles of prescription of opioids for chronic pain:
1. Single prescribing physician: There should be a single prescribing physician for all controlled substances.
 2. Single pharmacy: You should use a single pharmacy for prescription filling (whenever possible).
 3. Lowest possible dose: The lowest possible effective dose should be used to initiate therapy, and should be titrated, as needed to minimize both pain and medication side effects and maximize pain relief and improved function levels.
 4. Appearance of misuse of medications: Be sure to watch for and document any appearance of misuse of medications. Acquisition of drugs from other physicians, uncontrolled dose escalation or other aberrant behaviors must be carefully assessed. In all such patients, opioid use should be reconsidered and additional, more rigid guidelines applied if opioids are to be continued. In some cases tapering and discontinuation of opioid therapy will be necessary.
 5. Physicians should be diligent to avoid common mistakes such as continued escalation of opioid dose despite no change or worsening function, using opioids in pain syndromes known to be poorly responsive, and not addressing psychological issues and signs of abuse.
- D. Follow-up Care: Visits initially at least every 2 weeks for the first 2 to 4 months of treatment, then at least once every 4 to 8 weeks while receiving opioids. Assessment and documentation of functional levels, signs of abuse or aberrant drug behaviors and opioid related side effects should be performed at every visit. The physician should also counsel the patient regarding the goals of opioid therapy.
- E. Consultations: You must request a psychosocial and/or pain management specialist's consultation if:
1. Pain and functional status have not substantially improved after 2 to 4 months of opioid treatment.
 2. A patient has a history of chemical dependency.
 3. A patient appears to have a borderline and/or antisocial personality disorder or psychosis.
 4. Active Alcohol or other substance abuse.
 5. A patient appears to have significant problems with depression, anxiety or irritability.
- F. Laboratory studies and drug screens: Order relevant ongoing clinical or laboratory studies (especially liver or kidney function testing), including drug screens, up to three times a year on a random basis, and/or as indicated.

- G. Discontinuation vs. continuation of opioids: After a 6 month trial of opioid medications, a physician should determine whether opioid therapy is appropriate for the patient, in accordance with the following:
 - 1. If there has not been an overall improvement in function, opioids should usually be discontinued.
 - 2. If the patient has returned to work or has demonstrated substantial improvement both in function and reported pain level during a 6 month period, reasonable doses of opioids should continue.
- H. Weaning of opioids: Weaning can be done safely by way of a slower taper. Patients who undergo intensive treatment programs in a pain center or a drug rehabilitation center can be tapered off opioids in 1 to 2 weeks. Patients being treated in an office-based practice should be tapered more slowly, but the taper should rarely take more than 3 months.
- I. Opioid diversion and abuse: Currently abuse of opioids is escalating and physicians must be diligent in detecting abuse and preventing diversion. Close monitoring and follow-up care is essential. Physicians should use the Physician Monitoring Program offered by the Oklahoma Bureau of Narcotics. This online program at www.obn.state.ok.us monitors and records all Schedule II and III opioids for each patient. This is a new, federally funded program designed to help prevent doctor shopping and abuse.

V. USE OF ALL NARCOTICS AND OPIOID MEDICATIONS

Controlled-release oral and transdermal formulations (e.g. morphine, oxycodone, oxymorphone and fentanyl) are used for long-term opioid therapy. The goal for the use of these medications should include both enhanced comfort and improved physical and psychosocial functioning. Generally, long-acting opioids are safer, more effective and may lessen the risk of abuse. The analgesic benefits of controlled-release opioids should be balanced against the potential adverse consequence of long-term use. Concerns regarding long-term opioid use include risks of misuse, abuse, addiction and diversion. Side effects include tolerance, constipation and sedation. All of the elements outlined for the uses of opioid medications for chronic pain are required for prescribing sustained-release opioid medications. These elements include:

- A. Written Informed Consent and Treatment Agreement: The physician should discuss the risks and benefits of the use of sustained-release opioids with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is without medical decision-making capacity.
 - 1. Informed consent documentation must be signed by the patient.
 - 2. A written agreement between the physician and patient must be co-signed.
- B. Consultation: A consultation for review of the treatment plan by another physician who is knowledgeable in the medical management must be obtained every year for patients receiving controlled-release opioid medications. Consultation with a psychologist, licensed clinical social worker, or psychiatrist is required for patients that have a history of medication misuse, substance abuse or those suspected to have co-morbid psychiatric disorders. Pain management consultations and psychosocial

evaluations are considered medically necessary. Approval for these services is mandatory.

VI. PSYCHOSOCIAL EVALUATION AND TREATMENT

A licensed psychologist with a PhD, PsyD, or EdD credentials, or a physician with psychiatric MD/DO credentials may perform initial evaluation and treatment. In addition, a Licensed Clinical Social Worker (LCSW), or a Licensed Professional Counselor (LPC) may provide treatment. It is preferable that these professionals have education/training and experience in diagnosing and treating chronic pain disorders in injured workers.

Psychometric tests may be administered and interpreted by a licensed psychologist with PhD, PsyD, or EdD credentials, a Licensed Professional Counselor (LPC) with appropriate credentialing, or a psychiatric physician with appropriate experience or training.

A. Testing and Evaluation: Psychosocial evaluations and psychological testing are accepted and well-established diagnostic procedures that provide unique and useful information pertaining to the patient with chronic pain. All patients who are diagnosed as having chronic pain must be referred for *Initial Psychosocial Evaluation and Testing*. Psychosocial assessment requires consideration of variations in pain experience and expression because of factors such as gender, age, race, ethnicity, national origin, religion, sexual orientation, disability, language or socioeconomic status. The interpretations of the evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation. The initial psychosocial evaluation and interpretation should address the following areas:

1. History of Injury
 - a. Nature of injury
 - b. Current symptomatic complaints
 - c. Compliance with treatment
 - d. Coping strategies used, including perceived locus of control and fear avoidance
2. Health history
 - a. Psychiatric history
 - b. History of alcohol or substance abuse
 - c. Activities of daily living
 - d. Mental status exam
 - e. Previous injuries, including disability, impairment and compensation
3. Psychosocial History
 - a. Childhood history, including sexual, physical, emotional abuse and abandonment
 - b. Educational history
 - c. Family history, including disability and addictions
 - d. Marital history and other significant adulthood activities and events
 - e. Legal history, including criminal and civil litigation
 - f. Employment and military history
 - g. Signs of pre-injury psychological dysfunction

- h. Current interpersonal relations, support and living situation
 - 4. Psychological test results, if performed
 - 5. Provide a current psychiatric diagnosis consistent with the standards of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM).
 - 6. Identify the chronic pain patient who may be a danger to themselves.
 - 7. Determine if the chronic pain patient is at risk for medication misuse, abuse, addiction, or diversion.
 - 8. Distinguish between psychosocial conditions that are pre-existing and those that are aggravated by the current injury or are work related.
 - 9. Distinguish pre-existing psychological symptoms, traits, and vulnerabilities from current symptoms. Treatment of these conditions is appropriate when pre-existing conditions affect recovery from chronic pain.
 - 10. Identify patients needing treatment for depression, anxiety, or other psychological symptoms; as well as identify patients prone to somatization or symptoms magnification.
 - 11. Determine if further psychosocial interventions are indicated for patients diagnosed with chronic pain.
 - 12. Provide treatment recommendations with respect to specific goals, frequency, timeframes, and expected outcomes.
- B. Psychosocial and/or Psychiatric Treatment: Treatment is considered medically necessary whenever co-morbid psychosocial and/or psychological conditions are present in the chronic pain patient. Therapeutic modalities include, but are not limited to, medications, individual counseling and group counseling. The frequency of treatments should be determined on an individual basis. Suggested frequency and duration guidelines:
- 1. Frequency: 1 to 5 times weekly for the first 4 weeks, decreasing to 1 to 2 times per week for the second month. Thereafter, 2 to 4 times monthly with the exception of exacerbations which may require increased frequency of visits.
 - 2. Optimum duration: 2 to 6 months
 - 3. Maximum duration: 6 to 12 months, not to include visits for medication management

APPENDIX 1
OPIOID TREATMENT AGREEMENT (SAMPLE)

Patient Name: _____

Date: _____

Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist in your return to work effort.

For the doctor: Keep signed originals in the patient file; give a photocopy to the patient. Renew at least every year.

1. I understand that I have the following responsibilities:
 - a. I will take medications only at the dose and frequency prescribed.
 - b. I will not increase or change medications without the approval of this doctor.
 - c. I will actively participate in return-to-work efforts and in any program designed to improve function (including social, physical, psychological and daily or work activities).
 - d. I will not request opioids or any other pain medicine from physicians other than from this doctor. This doctor will approve or prescribe all other mind and mood altering drugs.
 - e. I will inform this doctor of all other medications that I am taking.
 - f. I will obtain all medications from one pharmacy, when possible known to this doctor with full consent to talk with the pharmacist given by signing this agreement.
 - g. I will protect my prescriptions and medications. Only one lost prescription or medication will be replaced in a single calendar year. I will keep all medications from children.
 - h. I agree to participate in psychiatric or psychological assessments, if necessary.
 - i. If I have an addiction problem, I will not use illegal or street drugs or alcohol. This doctor may ask me to follow through with a program to address this issue. Such programs may include the following:
 - Consultation with an Addiction Specialist
 - Individual Counseling
 - Inpatient or Outpatient treatment
2. I understand that in the event of an emergency, this doctor should be contacted and the problem will be discussed with the emergency room or other treating physician. Your doctor should be contacted and the problem will be discussed with the emergency room or other treating physician. I am responsible for signing a consent to request record transfer to this doctor. No more than 3 days of medications may be prescribed by the emergency room or other physician without this doctor's approval.
3. I understand that I will consent to random drug screening. A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.
4. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.
5. I understand that this doctor may stop prescribing opioids or change the treatment plan if:
 - a. I do not show any improvement in pain from opioids or my physical activity has not improved.
 - b. My behavior is inconsistent with the responsibilities outlined in #1 above.
 - c. I give, sell or misuse the opioid medications.
 - d. I develop rapid tolerance or loss of improvement from the treatment.
 - e. I obtain opioids from other than this doctor.
 - f. I refuse to cooperate when asked to get a drug screen.
 - g. If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.
 - h. If I am unable to keep follow-up appointments

Patient Signature

Date

Physician Signature

Date

APPENDIX 2
INFORMED CONSENT (SAMPLE)

YOUR SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF OPIOIDS:

You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness and tolerance. Also, you should know about the possible danger associated with the use of opioids while operating heavy equipment or driving.

POSSIBLE SIDE EFFECTS OF OPIOIDS:

- Confusion or other change in thinking abilities
- Nausea/Vomiting
- Constipation
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
- Breathing too slowly – overdose can stop your breathing and lead to death
- Aggravation of depression
- Sleepiness or drowsiness
- Dry mouth

THESE SIDE EFFECTS MAY BE MADE WORSE IF YOU MIX OPIOIDS WITH OTHER DRUGS, INCLUDING ALCOHOL.

RISKS:

- **Physical dependence.** This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following:

<i>Runny nose</i>	<i>Difficulty sleeping for several days</i>
<i>Diarrhea</i>	<i>Abdominal cramping</i>
<i>Sweating</i>	<i>'Goose bumps'</i>
<i>Rapid heart rate</i>	<i>Nervousness</i>
- **Psychological dependence.** This means it is possible that stopping the drug will cause you to miss or crave it.
- **Tolerance.** This means you may need more and more drug to get the same effect.
- **Addiction.** A small percentage of patients may develop addiction problems based on genetic or other factors.
- **Problems with pregnancy.** If you are pregnant or contemplating pregnancy, discuss with your physician.

RECOMMENDATIONS TO MANAGE YOUR MEDICATIONS:

- Keep a diary of the pain medications you are taking, the medication dose, time of day you are taking them, their effectiveness and any side effects you may be having.
- Use of a medication box that you can purchase at your pharmacy that is already divided in to the days of the week and times of the day so it is easier to remember when to take your medications.
- Take along only the amount of medicine you need when leaving home so there is less risk of losing all your medications at the same time.

Patient Signature

Date