



DEMOGRAPHICS

Patient Information: Need help with forms?  Y  N  
 Gender:  Male  Female  Other: \_\_\_\_\_ Preferred pronouns:  She/Her  He/Him  They/Them  
 Preferred Language:  English  Spanish  Other: \_\_\_\_\_  
 Social Security: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 May we leave a detailed voice message?  Y  N May we send a detailed text message?  Y  N  
 Primary Care Physician: (Name) \_\_\_\_\_ (Phone) \_\_\_\_\_  
 Referring Physician: (Name) \_\_\_\_\_ (Phone) \_\_\_\_\_  
 Preferred Pharmacy: (Name) \_\_\_\_\_ (Phone) \_\_\_\_\_  
 Do you have a cardiologist?  Y  N Cardiologist Name: \_\_\_\_\_ (Phone) \_\_\_\_\_  
 Emergency Contact: (Name) \_\_\_\_\_ (Phone) \_\_\_\_\_ (Relationship) \_\_\_\_\_  
 Do you live in an assistant living facility?  Y  N Name of facility: \_\_\_\_\_  
 (City) \_\_\_\_\_ (State) \_\_\_\_\_ Do you have an Advance Directive (Living Will)?  Y  N

EMPLOYMENT

Employer: \_\_\_\_\_ Occupation \_\_\_\_\_  
 Phone \_\_\_\_\_ (Address) \_\_\_\_\_  
 (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

NOTICE OF PRIVACY PRACTICE

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I have been provided a copy of Advanced Urology's Privacy Practices as required by the Health Insurance Portability Act (HIPAA) to ensure that I have been made aware of my privacy rights. \_\_\_\_\_ Initial Here

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

**I authorize Advanced Urology to release my health information to persons/organizations listed below:**

Name: \_\_\_\_\_ Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**By signing this document, I acknowledge the following:**

- I have reviewed this authorization to release my medical records and confirm it is correct.
- I understand that this authorization will remain in effect for a period of one (1) year, unless revoked.
- I may revoke this authorization at any time by writing to: Advanced Urology, ATTN: Medical Records
- 1561 Janmar Rd., Snellville, GA 30078: The revocation will become effective upon receipt of the notice.

\_\_\_\_\_  
 Signature of patient (or guardian)

\_\_\_\_\_  
 Date



Please *initial and sign* to your acknowledgement and consent for Medical Treatment, Notice of Privacy Practices, Authorization to release medical information and Payment Policy.

Thank you for choosing Advanced Urology as your provider. We are committed to providing you with quality and affordable health care. Please be sure to carefully read our payment policy. A copy will be provided upon request.

PAYMENT POLICY

- **Insurance.** We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. If your account is turned over to a collection agency, a \$100 collections processing fee will be added to any outstanding balance.
- **Non-covered services.** Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
- **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- **Claims submission.** We will submit your claims and assist you in any way we can to help get your claims paid. Please be aware that any unpaid balances are your responsibility.
- **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
- **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

\_\_\_\_\_ INITIAL HERE

CONSENT TO MEDICAL TREATMENT

I have reviewed and consent to the following:

- I voluntarily present for treatment and consent to my provider to provide my care. Such care may include, but is not limited to, diagnostic procedures, blood draws, laboratory tests, medication administration, and other procedures considered advisable in my diagnosis, treatment and course of care.
- I acknowledge that my treatment is intended to address specific illnesses and is not intended as a substitute for a primary care physician and that no guarantee can be made or has been made as to the results of treatments or examinations at Advanced Urology.
- In the event an employee has a needle stick or otherwise is exposed to my blood or body fluids, I consent to testing for HIV or Hepatitis C & B.

\_\_\_\_\_ INITIAL HERE

SIGNATURES

By signing below, I acknowledge that I have reviewed Advanced Urology's payment policy and consent to medical treatment.

Print name of person signing: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of patient (or guardian)

Date

**Authorization to obtain protected healthcare information**

Patient Name (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MI) \_\_\_\_\_ (Suffix) \_\_\_\_\_

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

 I authorize Advanced Urology to obtain and the named facilities to release to Advanced Urology my healthcare information.

This release applies to:

- All my healthcare information
- Healthcare information related to the following treatment, condition or dates

---

 Other \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**For Office Use Only**

Facility: (Name) \_\_\_\_\_

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

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

(Fax) \_\_\_\_\_

 \_\_\_\_\_  
 Signature of patient (or guardian)

 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date

 \_\_\_\_\_  
 Print name of person signing

 \_\_\_\_\_  
 Relationship to patient



|  |   |   |
|--|---|---|
|  | Patient Name: _____ Date of birth: _____  |   |
|  | Height: _____   | Weight: _____   |
|  | Please tell us the reason for your visit today: _____   |   |
| <b>ALLERGIES</b>   | Do you have any known allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Latex <input type="checkbox"/> Band-aids/Adhesives <input type="checkbox"/> Iodine |   |
|  | • List all medication allergies   |   |
|  | <b>Name of medication</b>   | <b>Reaction to medication</b>   |
|  |   |   |
|  | • Are you allergic to IVP Dye? _____  |   |
| <b>CURRENT</b>   | • List ALL current medications including over the counter, birth control, vitamins, herbals & prescriptions   |   |
|  | <b>Medication Name &amp; Dose</b>   | <b>Medication Name &amp; Dose</b>   |
|  |   |   |
|  |   |   |
| <b>PAST MEDICAL</b>  | • List ALL current or past medical conditions   |   |
|  | • List ALL surgeries including the year   |   |
|  |   |   |
|  |   |   |
| <b>FAMILY HISTORY</b>  | Is there any family history of cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No   |   |
|  | Please answer the following:  |   |
|  | Relationship? _____ Type: _____   | Mother <input type="checkbox"/> Living <input type="checkbox"/> Deceased                              |
|  | Relationship? _____ Type: _____   | Father <input type="checkbox"/> Living <input type="checkbox"/> Deceased                              |
|  | Relationship? _____ Type: _____   | Cause of death: _____   |
| <b>SOCIAL HISTORY</b>  | <b>Tobacco Use</b>  |   |
|  | • Do you use tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No (How long?) _____ (How much?) Packs/day: _____  |   |
|  | • Are you a former smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No (Quit date?) _____  |   |
|  | <b>Alcohol Use</b>  |   |
| • Do you consume alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No (Type?) <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor |   |   |
| How much? _____ drinks per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month (Date of last drink?) ___/___/___                                 |   |   |
|  | <b>Drug Use</b>   | Do you routinely use any illegal substances? <input type="checkbox"/> Yes <input type="checkbox"/> No |



|       |      |               |
|-------|------|---------------|
| Name: | DOB: | Today's date: |
|-------|------|---------------|

**The following questions ask about your bladder and urinary function.  
Please review and answer all questions as best as you can.**

| <b>Do you usually experience any of the following, and if so, how much are you bothered...</b> (Circle all that apply) | If yes, how much does this bother you? |                 |                   |                    |
|--|--|-----------------|-------------------|--------------------|
|  | <b>Not at all</b>                      | <b>Somewhat</b> | <b>Moderately</b> | <b>Quite a bit</b> |
| 1. Frequent urination  | 0                                      | 1               | 2                 | 3                  |
| 2. Small amounts of urine leakage (drops)  | 0                                      | 1               | 2                 | 3                  |
| 3. Leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom          | 0                                      | 1               | 2                 | 3                  |
| 4. Urine leakage related to physical activity (coughing, sneezing, or laughing)  | 0                                      | 1               | 2                 | 3                  |
| 5. Difficulty emptying your bladder  | 0                                      | 1               | 2                 | 3                  |
| 6. Pain or discomfort in the lower abdomen or genital region   | 0                                      | 1               | 2                 | 3                  |
| <b>Has urine leakage affected your...</b> (Circle all that apply)  | <b>Not at all</b>                      | <b>Slightly</b> | <b>Moderately</b> | <b>Greatly</b>     |
| 1. Ability to do household chores (cooking, housecleaning, laundry)?   | 0                                      | 1               | 2                 | 3                  |
| 2. Physical recreation such as walking, swimming, or other exercise?   | 0                                      | 1               | 2                 | 3                  |
| 3. Entertainment activities (movies, concerts, etc.)?  | 0                                      | 1               | 2                 | 3                  |
| 4. Ability to travel by car or bus more than 30 minutes from home?   | 0                                      | 1               | 2                 | 3                  |
| 5. Participation in social activities outside your home?   | 0                                      | 1               | 2                 | 3                  |
| 6. Emotional health (nervousness, depression, etc.)?   | 0                                      | 1               | 2                 | 3                  |
| 7. Feeling frustrated?   | 0                                      | 1               | 2                 | 3                  |

• If you checked "Yes" to any of the above problems, how long have you been experiencing this?  
 Less than 1 year     About 1 year     About 2 years     3 to 5 years     Greater than 5 years

• On average, how many times do you urinate during the daytime (Waking hours)? \_\_\_\_\_  
 • On average, how many times do you urinate overnight (Sleeping hours)? \_\_\_\_\_

• If you leak urine, how frequently does this occur?  
 Every day     A few times per week     A few times per month     Less than once per month     Never

▪ If you leak urine, how much do you lose at a given time?     drops     Small splashes     More

▪ Has urine leakage caused you to feel frustrated?     Not at all     Slightly     Moderately     Greatly

▪ Do you ever leak urine while asleep?     Yes     No

▪ Do you ever leak urine without awareness?     Yes     No

• What events trigger urine leakage? **(Check all that apply)**

Cough     Laugh     Sneeze     Exercise     Sex

Positional Changes     Urgency     Other: \_\_\_\_\_



- Have you noticed any of the following with regards to your urine stream? **(Check all that apply)**
  - Slow to start (hesitancy)       Weak stream       Slow stream       Intermittent stream
  - Dribbling after stream ends       Double voiding
- Do you need to do any of the following to help your bladder empty? **(Check all that apply)**
  - Bearing down       Pushing on lower abdomen
  - Position changes       Catheter usage
- Have you had a urinary tract infection (UTI) with a positive urine culture in the past year?  Yes       No
  - If yes, about how many have you had in the past year? \_\_\_\_\_
  - When was your most recent one (date)? \_\_\_\_\_
  - Do you think you may have one today?       Yes       No
- Have you noticed any blood in your urine?       Yes       No
- Do you have any burning or pain with urination?       Yes       No
- Do you ever have pain associated with a full bladder?       Yes       No
- Have you ever tried any medications for your bladder? **(Check all that apply)**
  - Detrol/Tolterodine       Ditropan/Oxybutynin       Vesicare/Solifenacin       Sanctura/Trospium
  - Toviaz/Fesoterodine       Enablex/Darifenacin       Myrbetriq/Mirabegron       Cardura/Flomax
  - Elmiron/PPS       Methenamine/Hipprex       D-Mannose       Antibiotics
- Have you had any side effects from the above medications? **(Check all that apply)**
  - Dry mouth       Dry eyes       Constipation       Urine retention
  - Impaired emptying       Other
- Do you have any of the following medical problems?
  - Glaucoma       Gastroparesis/Slow GI transit       Dementia
  - Hypertension       Myasthenia gravis       QT prolongation
- Have you had any of the following treatments/procedures for your bladder?
  - Sling/Sphincter     Urethral bulking     Botox in bladder     PTNS     PNE/Interstim     Hydrodistension
  - Pelvic floor physical therapy       Other \_\_\_\_\_



|       |      |               |
|-------|------|---------------|
| Name: | DOB: | Today's date: |
|-------|------|---------------|

**The following questions ask about your bowel function. Please review and answer all questions as best as you can.**

Do you usually experience any of the following? (Check all that apply)

|   |  |
|---|--|
| <input type="checkbox"/> The need to strain hard to have a bowel movement   | If yes, how much does this bother you?<br><input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit |
| <input type="checkbox"/> The feeling that you have not completely emptied your bowels at the end of a bowel movement  | If yes, how much does this bother you?<br><input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit |
| <input type="checkbox"/> Loss of stool beyond your control if stool is well-formed  | If yes, how much does this bother you?<br><input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit |
| <input type="checkbox"/> Loss of stool beyond your control if stool is loose  | If yes, how much does this bother you?<br><input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit |
| <input type="checkbox"/> Loss of gas from rectum beyond your control  | If yes, how much does this bother you?<br><input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit |
| <input type="checkbox"/> Pain when you pass stool   | If yes, how much does this bother you?<br><input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit |
| <input type="checkbox"/> Strong sense of urgency to have to rush to the bathroom to have a bowel movement   | If yes, how much does this bother you?<br><input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit |
| <input type="checkbox"/> Part of your bowel passing through the rectum and bulging outside during or after a bowel movement   | If yes, how much does this bother you?<br><input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit |
| <ul style="list-style-type: none"> <li>• If you have leakage of stool and/or gas, how often does this happen?<br/> <input type="checkbox"/> Daily    <input type="checkbox"/> A few times per week    <input type="checkbox"/> A few times per month    <input type="checkbox"/> Every few months</li> </ul>  |  |
| <ul style="list-style-type: none"> <li>• Do you use any pads or liners for stool leakage?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</li> <li>• Do you have constipation?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</li> <li>• Do you have hard stools that are difficult to pass?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</li> <li>• On average, how many bowel movements do you have a week? _____</li> <li>• Do you have diarrhea?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</li> </ul> |  |



- Have you tried any of the following medications for your bowels? **(Check all that apply)**
  - Fiber supplementation     Stool softeners     Laxatives     Enemas     Linzess/Linaclotide
  - Prudac/Prucalopride     Xifaxin/Rifaximin     Viberzi/Eluxadoline     Lomotil
  - Imodium     Other \_\_\_\_\_
  
- Have you had any of the following treatments for bowel leakage? **(Check all that apply)**
  - Sphincteroplasty     PNE/Interstim     PTNS     Solesta injection     Botox
  - Artificial sphincter     TOPAS     Anal sphincter bulking     Pelvic floor physical therapy
  
- When was your last colonoscopy? \_\_\_\_\_
  - Normal     Abnormal [Findings \_\_\_\_\_]
  
- Do you have a history of any of the following? **(Check all that apply)**
  - Hemorrhoids     Anal fissures     Anal fistulas     Inflammatory bowel disease
  - Colorectal cancer     Rectal prolapse     IBS     Slow GI motility     Celiac disease
  - Hirschsprung's disease     Other \_\_\_\_\_



Please encircle the response that best describes you. Your provider will use this form to assess your symptoms and will discuss your score with you.

| <b>SHIM</b>   |                              | <b>Name:</b>          |                  |                           |                                |
|---|------------------------------|-----------------------|------------------|---------------------------|--------------------------------|
| <b>Over the past 6 months</b>   | <b>Very Low</b>              | <b>Low</b>            | <b>Moderate</b>  | <b>High</b>               | <b>Very High</b>               |
| How would you rate your confidence that you could get and keep an erection?   | 1                            | 2                     | 3                | 4                         | 5                              |
| <b>Over the past 6 months</b>   | <b>Almost never or never</b> | <b>A few times</b>    | <b>Sometimes</b> | <b>Most times</b>         | <b>Almost always or always</b> |
| When you had erections with sexual stimulation, how often were your erections hard enough for penetration?          | 1                            | 2                     | 3                | 4                         | 5                              |
| <b>Over the past 6 months</b>   | <b>Almost never or never</b> | <b>A few times</b>    | <b>Sometimes</b> | <b>Most times</b>         | <b>Almost always or always</b> |
| During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner? | 1                            | 2                     | 3                | 4                         | 5                              |
| <b>Over the past 6 months</b>   | <b>Extremely difficult</b>   | <b>Very difficult</b> | <b>Difficult</b> | <b>Slightly Difficult</b> | <b>Not difficult</b>           |
| During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?             | 1                            | 2                     | 3                | 4                         | 5                              |
| <b>Over the past 6 months</b>   | <b>Almost never or never</b> | <b>A few times</b>    | <b>Sometimes</b> | <b>Most times</b>         | <b>Almost always or always</b> |
| When you attempted sexual intercourse, how often was it satisfactory for you?                                       | 1                            | 2                     | 3                | 4                         | 5                              |

**Total Score:** \_\_\_\_\_

1-7 Severe ED    8-11 Moderate ED    12-16: Mild-moderate ED    17-21: Mild ED    22-25: No ED

| <b>Adjunct to SHIM</b>  |                            |                               |                              |                             |                                |
|---|----------------------------|-------------------------------|------------------------------|-----------------------------|--------------------------------|
| 1. Do you have urinary leakage with sexual activity or orgasm?                |                            |                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                                |
|   | Never or almost never [0%] | Less than half the time [25%] | About half the time [50%]    | Over half the time [75%]    | Always or almost always [100%] |
| 2. Do you ejaculate before you want to?                                       | 0                          | 1                             | 2                            | 3                           | 4                              |
| 3. Do you ejaculate with very little stimulation?                             | 0                          | 1                             | 2                            | 3                           | 4                              |
| 4. Have you noticed a bend or abnormal shape to your penis during erections?  |                            |                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                                |
| 5. Is this penile deformity negatively affecting sex for you or your partner? |                            |                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                                |



Many men over the age of 40 suffer from Benign Prostatic Hyperplasia (BPH). This is a non-cancerous enlargement of the prostate. Your provider will use this form to assess your symptoms and will discuss your score with you.

| <b>AUA AND BPH SYMPTOM SCORE</b>  |                   | <b>Name:</b>                 |                                |                            |                                |                      |
|---|-------------------|------------------------------|--------------------------------|----------------------------|--------------------------------|----------------------|
| <b>DIRECTIONS</b> - Thinking over the past month, check what best describes the following. Then add all the checked numbers to get the total score            | <b>Not at all</b> | <b>Less than 1 - 5 times</b> | <b>Less than half the time</b> | <b>About half the time</b> | <b>More than half the time</b> | <b>Almost Always</b> |
| <b>1. INCOMPLETE EMPTYING</b> – Over the past month, how often have you had the feeling of not completely emptying your bladder after you finished urinating? | 0                 | 1                            | 2                              | 3                          | 4                              | 5                    |
| <b>FREQUENCY</b> – Over the past month, how often did you have to urinate again less than 2 hours after you had finished urinating?                           | 0                 | 1                            | 2                              | 3                          | 4                              | 5                    |
| <b>INTERMITTENCY</b> – Over the past month, how often did you stop and start again several times while urinating?   | 0                 | 1                            | 2                              | 3                          | 4                              | 5                    |
| <b>URGE TO URINATE</b> – Over the past month, how often did you find it difficult to postpone urination?  | 0                 | 1                            | 2                              | 3                          | 4                              | 5                    |
| <b>WEAK STREAM</b> – Over the past month, how often did you have a weak urinary stream?   | 0                 | 1                            | 2                              | 3                          | 4                              | 5                    |
| <b>STRAINING</b> – Over the past month, how often did you have to push or strain to begin urination?  | 0                 | 1                            | 2                              | 3                          | 4                              | 5                    |
| <b>URINATING AT NIGHT</b> – Over the past month, how many times do you typically get up at night to urinate after going to bed?                               | 0                 | 1                            | 2                              | 3                          | 4                              | 5                    |
| <b>Symptom Score: 1 – 7 Mild, 8 – 19 Moderate, 20 – 35 Severe</b>   |                   |                              |                                | <b>TOTAL SCORE:</b>        |                                |                      |

| <b>BOTHER SCORE DUE TO URINARY SYMPTOMS</b>  |                  |                |                         |              |                            |                 |
|--|------------------|----------------|-------------------------|--------------|----------------------------|-----------------|
| Rate the bothersome level of your urinary symptoms by checking what best describes your feelings       | <b>Delighted</b> | <b>Pleased</b> | <b>Mostly Satisfied</b> | <b>Mixed</b> | <b>Mostly Dissatisfied</b> | <b>Terrible</b> |
| How would you feel living the rest of your life with your current urinary condition the way it is now? | 0                | 1              | 2                       | 3            | 4                          | 5               |

|  |                                     |                                    |
|--|-------------------------------------|------------------------------------|
| <b>Are you interested in minimally invasive surgical intervention?</b> | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
|--|-------------------------------------|------------------------------------|



Patient Name (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MI) \_\_\_\_\_ (Suffix) \_\_\_\_\_

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

You may potentially receive opioid/narcotic therapy post operatively of the treatment of pain short term. It is vital that you understand these drugs are very useful but have a potential for misuse and are therefore closely controlled by local, state and federal governments.

The goal of this treatment is to:

- Reduce your pain
- Improve your level of function in performing your activities of daily living.

Our goal at Advanced Urology is to not initiate or continue opioid therapy whenever possible, but sometimes this may be warranted for more effective pain management.

Long term prescriptions for chronic pain will **NOT** be prescribed by any physician in the Advanced Urology practice. Any individual needing long term opioid/narcotic therapy for chronic pain will be referred to a pain management specialist.

**SIDE EFFECTS**

The potential side effects and risks of these medications include, but are not limited to:

- Mood changes
- Drowsiness
- Dizziness
- Constipation
- Nausea
- Confusion
- Decreased sexual function and libido (Your hormone levels can be monitored during your treatment)

Many of these side effects will resolve over days or weeks. Constipation often persists and may require additional medication. If other side effects persist, different opioids may be tried, or they may be discontinued.

You Should **NOT**:

- **Operate a vehicle or machinery**
  - Driving while taking opioids for chronic pain is considered medically acceptable as long as you do not have side effects such as sedation or altered mental status. These side effects usually do not occur while taking opioids/narcotics chronically. However, it is possible that you could be considered DUI if stopped by law enforcement while driving.
- **Consume ANY alcohol while taking opioids/narcotics**
  - The effects of alcohol and sedatives are additive with those of opioids/narcotics. If you take these substances in combination with opioids/narcotics, a dangerous situation could result, such as coma, organ damage or even **DEATH**.
- **Take any other non-prescribed sedative medication while taking opioids/narcotics**

Patient's Initials: \_\_\_\_\_



**RISKS**

- **Dependence**
  - Physical dependence is an expected side effect of long-term opioid/narcotic therapy. This means that if you take opioids/narcotics continuously, and then stop them abruptly, you will experience a withdrawal syndrome. This syndrome often includes sweating, diarrhea, irritability, sleeplessness, runny nose, tearing, muscle and bone aching, gooseflesh, and dilated pupils. Withdrawal can be life-threatening. To prevent these symptoms, the opioids/narcotics should be taken regularly or, if discontinued, reduced gradually under the supervision of your physician.
  
- **Tolerance**
  - Tolerance to the pain-relieving effect of opioids/narcotics is possible with continued use. This means that more medication is required to achieve the same level of pain control experienced when the opioid/narcotic therapy was initiated. This may occur even though there has been no change in your underlying painful condition. When tolerance does occur, sometimes it requires tapering or discontinuation of the opioid/narcotic. Sometimes tolerance can be treated by substituting a different opioid/narcotic. When initiated, doses of medications must be adjusted to achieve a therapeutic, pain relieving effect; upward adjustments during this period are not viewed as tolerance.
  
- **Increased Pain (Hyperalgesia)**
  - The long-term effects of opioids/narcotics on the body's own pain-fighting systems are unknown. Some evidence suggests that opioids/narcotics may interfere with pain modulation, resulting in an increased sensitivity to pain. Sometimes individuals who have been on long-term opioids/narcotics, but who continue to have pain, note decreased pain after several weeks off the medications.
  
- **Addiction**
  - Addiction is a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing the development and manifestations. It is characterized by behaviors that include one or more of the following:
    - Impaired control over drug use
    - Compulsive use
    - Continued use despite harm
    - Craving

**RISK TO UNBORN CHILDREN**

Children born to women who are taking opioids/narcotics on a regular basis will likely be physically dependent at birth. Women of childbearing age should maintain safe and effective birth control while on opioid/narcotic therapy. Should you become pregnant, immediately contact your physician and the medication will be tapered and stopped.

**LONG-TERM SIDE EFFECTS**

The long-term effect of opioid/narcotic therapy is not fully known. Most of the long-term effects have been listed above. If you have additional questions regarding the potential long-term effects of opioid/narcotic therapy, please speak with your physician.

Patient's Initials: \_\_\_\_\_



**PRESCRIPTIONS & USE OF OPIOID/NARCOTIC MEDICATIONS**

Your medication will be prescribed by your physician for control of pain. Based on your individual needs, you will be provided prescription medication short term or post operatively.

- You agree and understand that increasing your dose without the close supervision of your physician could lead to drug overdose, causing severe sedation, respiratory depression and/or death.
- You agree and understand that opioid/narcotic medication is strictly prescribed for you, and your opioid/narcotic medication should NEVER be given to others.
- You agree to fill opioid/narcotic prescriptions at one pharmacy.
- You agree to secure your opioid/narcotic medications in safe, locked source to prevent loss or theft. You are responsible for any loss of theft.
- You agree that lost, stolen or destroyed prescriptions or drugs will not be replaced, and may result in discontinuation of treatment.
- You agree to obtain opioid/narcotic medication from one prescribing physician or that physician's substitute if your prescribing physician is not available and your prescribing physician has authorized his or her substitute to provide treatment.
- You agree to submit to blood and/or urine testing to monitor the levels of medication or other drugs and any organ side effects. You also agree that other doctors and law enforcement may be notified of the results.
- You understand and agree that if you lose your medication or run out early due to overuse, you may experience and go through withdrawal from opioids/narcotics. You further understand and agree that you are solely responsible for your own medications.
- You agree to provide a list from your pharmacy detailing all medications received from that pharmacy and to provide updated lists as requested by your physician.

***For patients taking methadone: Methadone has significant interactions with many other medications. Some of these medications may reduce your body's ability to metabolize methadone, thus INCREASING the methadone in your body, which could be dangerous. Therefore, you MUST notify this office of ALL medications prescribed for ANY condition while taking methadone.***

**OPIOID/NARCOTIC THERAPY MAY BE DISCONTINUED IF YOU:**

- Develop progressive tolerance which cannot be managed by changing medications
- Experience unacceptable side effects which cannot be controlled
- Experience diminishing function or poor pain control
- Develop signs of addiction
- Abuse any other controlled substance (this may be determined by random blood/urine testing)
- Obtain and or use street drugs (this may be determined by random blood/urine testing)
- Increase your medication without the consent of your physician
- Obtain opiates/narcotics from other physicians or sources
- Fill prescriptions at other pharmacies without explanation
- Sell, give away, or lose medications
- Violate any of the terms of this agreement

Patient's Initials: \_\_\_\_\_

**BY SIGNING BELOW, I ACKNOWLEDGE AND AGREE TO THE FOLLOWING:**

- I have read and fully understand the Physician/Patient Informed Consent and Agreement for Opioid/Narcotic Therapy for the Treatment of Pain
- I have been given the opportunity to ask questions about the proposed treatment (including no treatment), potential risks, complications, side effects, and benefits
- I knowingly accept and agree to assume the risks of the proposed treatment as presented
- I agree to abide by the terms of this agreement

\_\_\_\_\_  
Patient Name (Please Print Clearly)

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Name (Please Print Clearly)

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Name (Please Print Clearly)

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date