PAIN MANAGEMENT/CONTROLLED SUBSTANCE AGREEMENT

- **The purpose of this Agreement is to prevent misunderstandings** about certain medicines you will be taking for pain management or controlled substance such as anti-anxiety medication (Examples-Valium, Xanax) or ADD/ADHD medications. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals. _____ Pt. Initials

- **I understand that this Agreement is essential to the trust and confidence** necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement. _____ pt. Initials

- **Because these medicines have the potential for abuse or diversion, strict accountability is necessary**.

- **I understand that if I break this Agreement**, my doctor will stop prescribing these pain-control medications/controlled substances _____Pt. initials

- **I agree to notify my doctor of any and all pain medications or prescriptions that I receive from other providers** (effective from date of this agreement and ongoing). Such notification should occur by next business day following receipt of prescription. If I fail to alert my doctor I understand I may be discharged from the practice. _____Pt. initials

- **I understand that someday my doctor may wean me partially or totally from narcotics** if he/she determines that, in the long run, this is likely to be in my best interests. In such situations other meds or therapies will likely be suggested as part of my new treatment plan. I agree to respect my doctor's opinion in such circumstances and comply with the new treatment plan ____Pt. Initials

- **I understand that if I am suspected of diverting or distributing my pain medications/controlled substances, my doctor will immediately cease prescribing** these medications. In this case, my doctor will be required to comply with local state and/or federal reporting requirements and investigation._____ Pt. initials

- **I would also be amenable** to seeking psychiatric treatment, psychotherapy and/or psychological treatment if my doctor deems necessary. ____ Pt initials

- **I agree to l communicate fully and honestly with my doctor** about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain. ____ Pt initials

- If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy. I also understand that my state may have regulations concerning driving while under the influence of drugs and accept responsibility for adhering to those regulations. ____ Pt. Initials

- **I understand the use of opiates or pain medications in combination with anti-anxiety medications such as Valium or Xanax may cause me to stop breathing and abnormal heart rhythms resulting in injury or death**. ____Pt. initials

- **I understand that strong medications, which may include opiates and other controlled substances, which I may be prescribed, have potential risks and side effects, including the risk of addiction**. An over-dosage with an opiate medication may cause injury or death. Other possible complications include, but are not limited to, constipation, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function. ____Pt. Initials

- **I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances**. Use of alcohol will be limited to a time when I am not driving, operating machinery and will be infrequent. ____Pt. Initials

- **I will not share, sell or trade my medication with anyone**. ___Pt. Initials

- **I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor**. _____ Pt. Initials

- **I will inform my doctor of ALL current medications** including herbs, vitamins, supplements, and over-the-counter medications. I will provide an updated medication list during every visit. _____ Pt. Initials

- **I will not alter my medicine in any way or use any other administrative method other than what has been prescribed**.
  Long-term agents (MS Contin, Oxycontin, etc.) must be taken whole and are not allowed to be broken, chewed, crushed, injected and/or snorted. Potential toxicity could occur due to rapid absorption if taken inappropriately, which may lead to death. _____Pt. Initials
- **I understand that suddenly stopping some medications** (including opioids and sedatives) can cause substantial discomfort over and above any increase in my chronic pain causing psychological distress, extreme achiness and fatigue, nausea, trembling, etc. _____Pt. Initials

- **I will avoid withdrawal symptoms** by budgeting my pills, not taking more medications than prescribed, and keeping my appointments for refills. I understand that 'running out' of itself is not grounds for insisting on an 'emergency or urgent appointment'. ____Pt. initials

- **I will safeguard my pain medicine/controlled substances from loss or theft**. Lost or stolen medicines will not be replaced. _____Pt. Initials

- **I agree that refills of my prescriptions for pain medicine/controlled substance will be made only at the time of an office visit or during regular office hours**. No refills will be available during evenings or on weekends. _____Pt. Initials

- **I agree that prescriptions for pain medicine/controlled substances will not be refilled earlier than the agreed upon renewal date**. _____Pt. Initials

- **(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 prescriber/provider may check my blood or request that my primary care provider do routine testing to see if my testosterone level is normal. Please be aware your insurance may not cover this test, therefore if deemed medically necessary you agree to be responsible for any costs not covered by your insurance. ____ Pt. Initials

- **(Females Only) If I plan to become pregnant or believe that I have become pregnant while taking this medication, I will immediately call my obstetric doctor and prescribing prescriber/provider to inform them**. I am aware that should I carry a baby to delivery while taking these medications, the baby will be physically dependent upon opioids. Infant drug withdrawal can be life threatening. If a female of childbearing age, I certify that I am not pregnant and will use appropriate contraceptive measures during the course of treatment with opioids/controlled substances. ____ Pt. Initials

I agree to use _____Pharmacy,

Located at_____,

Telephone number _____, for filling prescriptions for ***all*** of my pain medicine/controlled substance.

- **If I chose to have my medications filled by a new pharmacy not listed above**, I will be required to sign an amendment to this agreement with my updated pharmacy information. _____ Pt. Initials

- **I understand that changing date, quantity, or strength of medicines or altering a prescription in any way is against the law**. Forged prescriptions and/or forged provider's signatures are also against the law. If any of these instances occur, it will result in an immediate termination from this practice._____Pt. Initials

- **I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine or other controlled substances.** I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. _____ Pt. Initials

- I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine/controlled substance. Tests may include screens for illegal substances, and your cooperation is required. **Refusal of such testing may subject you to an abrupt / rapid wean schedule in order for the medication to be discontinued or prompt termination from care. ____Pt. Initials**

- **I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time**. _____Pt. Initials

- I will bring all unused pain medicine or controlled substance to every office visit related to the management of my pain treatment program _____Pt. Initials

- I understand that any serious misbehavior such as yelling, threatening, cursing, etc will likely be cause for dismissal from the practice. _____Pt. Initials

- **I agree to follow the guidelines that have been fully explained to me**. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me. _____Pt. Initials

This agreement is entered into on this _____day of _____, _____.

Patient signature:

_____

Prescriber/provider signature:

_____

Witnessed by:

_____