

## NARCOTIC MEDICATION AGREEMENT

You have agreed to receive narcotics for the treatment of your pain. It is important that you have an understanding of the risks and responsibilities that go along with this treatment. Please read each statement and sign this agreement/contract below. If you have any questions regarding this information or the office policy regarding the prescribing of narcotics, please request clarification.

I, \_\_\_\_\_, understand that:

**(Print Patient's Name)**

Any medical treatment is initially a trial, and that continued prescription is based on evidence of benefit. I understand that the goal of using narcotics is to decrease my pain and increase my functional level. If my pain does not significantly decrease and/or my function increase, the medication will be stopped.

I am aware that the use of such medicine has risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, lightheadedness, dizziness, confusion, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, kidney or liver disease, sexual dysfunction, physical dependence, tolerance to analgesia, addiction, withdrawal and the possibility that the medicine will not provide complete relief.

The overuse of narcotic medication can result in serious health risks including respiratory depression or even death.

Medications will be strictly monitored and all of my medications should be filled at the same pharmacy. (Should the need arise to change pharmacies our office must be informed).

**The pharmacy that I have selected is:**

\_\_\_\_\_

I will not call the office to have a prescription called in after office hours.

**I am responsible for making and keeping scheduled appointments. Early refill requests will not be honored.**

I will take the narcotic medication only as prescribed. Any changes must first be discussed and agreed upon with Pain Medicine Specialty Group's physician.



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**Medications will not be replaced for any reasons including if they are lost, get wet, are destroyed, stolen, etc.** 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.

**I agree that only my physician at Pain Medicine Specialty Group will prescribe my narcotic medication unless it is authorized by us under limited circumstances.** I will not obtain or use narcotics or other controlled substances from a source other than Pain Medicine Specialty Group. I will instruct my other physicians to confer with the Pain Medicine Specialty Group for any changes or need for additional narcotic medications. If it is brought to the attention of Pain Medicine Specialty Group that other providers are prescribing medications for me, Pain Medicine Specialty Group reserves the right to discontinue prescribing medications and/or discharge me from the clinic.

I have been given a copy of the Pain Medicine Specialty Group – Long Term Opioid Analgesic Medication Information packet and understand that I may ask the physician and/or pharmacist questions about my medication and treatment.

I will inform Pain Medicine Specialty Group's physician of any changes in my medical condition, including pregnancy, any changes in any prescription and/or over the counter medication that I take and of any side effects that I may experience from any of the medications that I take.

I agree to tell my Pain Medicine Specialty Group's physician my complete and honest personal drug / medication usage and history.

I will not use any illegal "street drugs" while receiving medications from Pain Medicine Specialty Group.

I will communicate fully and honestly with my physician 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.

Routine blood work and random drug screens or pill counts may be a part of my treatment plan. I agree to have them done on the day the physician requests it.

The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability.



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If the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to my records.

It is a felony to obtain narcotic medications under false pretenses, forged or altered prescriptions. This could include getting medication from more than one doctor, misrepresenting myself to obtain medications, using them in a manner other than prescribed or diverting the medications in any other way (selling). These acts will be reported to law enforcement authority.

I know that narcotic medications will be **stopped** if any of the following occurs:

- ❖ I trade, sell, or misuse the medication
- ❖ I have broken any part of this agreement
- ❖ I do not go for a blood or urine test when asked
- ❖ My blood or urine test shows the presence of medications that our physician is not aware of, the presence of illegal drugs, or does not show medications that I am receiving a prescription for
- ❖ I get narcotics from sources other than Pain Medicine Specialty Group
- ❖ Our physician feels that it is in my best interest that narcotic treatment be stopped
- ❖ Any aggressive behavior or verbal abuse toward physician or staff
- ❖ I consistently miss scheduled appointments.

It is understood that failure to adhere to this agreement may result in cessation of therapy with controlled substance prescribing (no narcotic prescriptions will be written) by Pain Medicine Specialty Group.

I have read the Narcotic Medication Agreement and without question understand all of this agreement. By signing this agreement I affirm that I have read, understand and accept all of the terms of this agreement.

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

Clinic Witness: \_\_\_\_\_ Date: \_\_\_\_\_