CONTROLLED 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:

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.

The use of such medicine has certain 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.

This medication 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:

Pharmacy: ____________________________________________ Pharmacy Phone: ____________________

I will NOT request medication refills on evenings, weekends, holidays, or after 4 pm on weekdays. I will request refill prescriptions at least 3 business days in advance between the hours of 9am and 4pm. It is my sole responsibility to request my medication refills in advance of my physician’s scheduled absences. I understand that by failing to do so may result in delayed refill of medications and may lead to withdrawal symptoms.

Prescription refill request cannot be called into the pharmacy. Early refill request will not be honored.

Medications will not be replaced due to patient neglect i.e., lost or damaged. They should not be left where others might see or otherwise have access to them. If my medication has been stolen and I complete a police report regarding the theft, an exception may be made at the discretion of the physician. It is expected that you will take the highest possible degree of care with your medication and prescription.

I will inform my St John Clinic Pain Management physician of any changes in my medical condition and prescription, and/or over the counter medication that I take and of any adverse effects that I may experience from any of the medications.

Only my St John Physician Pain Management physician will prescribe my narcotic medication. I will not obtain or use narcotics or other controlled substances from a source other than St John Clinic Pain Management. I will instruct my other physicians to confer with the St John Clinic Pain Management physician for anything related to the use of controlled substances.

I will take the narcotic medication only as prescribed. Any changes must first be discussed and agreed upon with your St John Clinic Pain Management Physician.
CONTROLLED MEDICATION AGREEMENT (continued)

If it is brought to the attention of the clinic that other providers are prescribing medications for me, St John Clinic Pain Management physicians reserve the right to discontinue prescribing medications and/or discharge me from the clinic.

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

I agree to tell my Pain Management physician my complete and honest personal drug/medication usage and history.

I will not use any illegal “street drugs” while receiving medications from St John Clinic Pain Management.

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 may be a part of my treatment plan. I agree to have them done on the day the physician requests it.

It is a felony to obtain narcotic medications under false pretenses. 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).

I know that narcotic medications will be stopped if any of the following occurs:
  • I trade, sell, or misuse the medication
  • The clinic finds that 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 the staff are 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 St John Clinic Pain Management
  • Any member of the professional staff of St John Clinic Pain Management feels that it is in my best interests that narcotic treatment is stopped
  • Any aggressive behavior 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 St John Physicians Pain Management.

I, _________________________________, have read the Controlled Medication Agreement and my questions have been answered. By signing this agreement, I confirm that I have read, understand and accept all of the terms of this agreement.

Patient Signature: _________________________________ Date: ________________

Clinic Witness: _________________________________ Date: ________________