

MEDICATION THERAPY CONTRACT

Office hours are Monday through Friday, 8:30 am to 4:30 pm. Medications refills will not be filled after hours, on weekends, or on holidays or outside the parameters of state and federal guidelines. It is the patient's responsibility to request medication refills by making a scheduled appointment to be seen and/or examined by the physician during normal business hours. To receive narcotic medications you must be seen in the office every 30 days.

I am aware that the use of such medicine has certain risks associated with it, including but not limited to, sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief. **This decision has been made based on my current medical condition.**

I am aware of the possible risks and benefits of other types of treatments that do not involve the use of Opioid/controlled medications. I will tell my physician about all other medicines and treatments that I am receiving. **I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: Using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for his/her self.** _____ (initials)

I am aware that certain medicines such as nalbuphine (Nubain), pentazocaine (Talwin), buprenorphine (Buprenex), and butorphanol (Stadol), may reverse the action of the medicine I am using for pain control.

Taking any of these medications while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other physicians that I am taking pain medications and cannot take any of the medicines listed above.

I am aware that addiction to my pain medicine is low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has family or personal history of addiction. I agree to tell my physician my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time.

I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and flu-like feeling. I am aware that Opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help, and may cause unacceptable side effects. Tolerance or failure to respond well to Opioids may cause my physician to choose another form of treatment.

I understand that failure to comply with the prescribed medication plan may lead to increased urine screenings on a frequent basis and random basis for medications that are prescribed to me. I also understand that if my physician suspects I am abusing medications, diverting use of my medications or have a problem with taking opioid due to addiction, I may be referred to an addictionologist or certified addiction specialist for further counseling. Failure to follow advised therapy or treatment may be cause for discharge from the practice.

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 physician or family physician may check my blood to see if my testosterone level is normal.

FEMALES ONLY: If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric physician and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines; the baby will be physically dependent on Opioids. I am aware that the use of Opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an Opioid.

Summary of Guidelines for prescribed Opiates:

1. The patient must provide copies of reports from previous and concurrent treating physicians.
2. The patient must provide The Pain Institute accurate patient address and phone number and keep us up to date of any changes in their personal information.
3. **THE PAIN INSTITUTE WILL BE THE ONLY PROVIDER TO PRESCRIBE NARCOTIC AND/OR CONTROLLED MEDICATIONS.**
4. The patient must provide us with the name and phone number of the pharmacy that the patient is using and keep us up to date with any changes.
5. The patient must be seen for regular office visits to receive a medication refill. Prescriptions will be written for a 30-day supply.
6. The patient is responsible for all prescriptions/medications given and must understand that if the prescriptions/medications are lost, misplaced or destroyed; the prescriptions/medications **cannot be replaced.**
7. We reserve the right to do a random pill count. It is your responsibility to take the medications as prescribed by your physician, **DO NOT** increase at your own discretion.
8. **NO REFILLS WILL BE MADE AFTER HOURS, ON WEEKENDS OR HOLIDAYS.**
9. Other therapies may be ordered to assist the pain management such as nerve blocks, TENS, physical or occupational therapy, psychological counseling as appropriate to the diagnosis.
10. "Street Drugs" such as marijuana, cocaine, amphetamines, etc. are in themselves dangerous and illegal. Mixed with some of the medicines often used in pain management, the combination could be lethal. Evidence of altering a prescription or obtaining controlled substances from other sources will require notification of law enforcement agencies as needed.
11. We will randomly check the patient's urine for compliance with therapy. The urine will be tested for the presence of the prescribed drugs as well as several other drugs, including illegal drugs.
12. The patient understands that if their urine sample contains illegal substances, we may end the patient-doctor relationship.
13. The patient has the right to refuse such random urine testing. The Pain Institute reserves the right to end the patient-doctor relationship on a patient that refuses to comply with our urine drug testing policy.

The patient authorizes any physician office, hospital, or clinic to provide full details of medical history and treatment to The Pain Institute for the use of continuity of care by completing a medical release form up to date.

Any breach of these guidelines may result in the patient being discharged from the practice of The Pain Institute.

I have read this form or have had this form read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with Opioid pain medications.

Patient signature Date

Patient Name (PRINT) Date

Witness printed name and signature Date

I acknowledge this agreement but I am signing that I am declining any medications.

Patient Name (PRINT) Date