Michele Delzer, CNP

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Pain Management Controlled Substance Consent and Treatment Agreement

Patient Name: _____
Date of Birth: _____
Provider: Michele Delzer, CNP
Date: _____

Purpose

This agreement outlines the safe and responsible use of controlled substances prescribed for **non-cancer pain management**. The goals are to reduce pain, improve function, and maintain quality of life while minimizing risks, including dependence, misuse, and side effects.

Treatment Plan

- Controlled substances are prescribed **to improve function**, not necessarily to eliminate pain entirely.
- Treatment may include medications, physical therapy, lifestyle interventions, and other complementary treatments as determined by the provider.
- **Regular follow-up appointments** are required to monitor safety, efficacy, and side effects.

Patient Responsibilities

1. Take medications **exactly as prescribed**; do not alter dose or frequency without approval.
2. **Do not share, sell, or give medication** to anyone.
3. Use **one pharmacy** whenever possible for all prescriptions.
4. Inform the provider of **all medications, supplements, and health changes**.
5. Keep all scheduled appointments; missed appointments may result in changes or discontinuation of therapy.
6. Report **any side effects or concerning symptoms** immediately.

Risks and Potential Side Effects

Controlled substances may cause:

- Drowsiness, dizziness, or impaired concentration
- Constipation or gastrointestinal issues
- Dependence, tolerance, or addiction
- Respiratory depression (rare, serious)
- Interactions with other medications, alcohol, or supplements

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Monitoring and Compliance

- Patients may be asked to provide **urine, blood, or other lab tests** to monitor compliance.
- Early refills may not be granted; **lost or stolen medications may not be replaced**.
- Noncompliance may result in **discontinuation of controlled substances**.

Acknowledgment and Consent

I have read, understand, and agree to this Pain Management Controlled Substance Agreement. I have had the opportunity to ask questions and understand that noncompliance may result in modification or discontinuation of my therapy.

Patient Signature: _____
Date: _____

Provider Signature: _____
Date: _____