NARCOTIC AGREEMENT

The purpose of this agreement is to maintain a safe, controlled treatment plan. I am asking for narcotic pain medication because other treatments and medication I have received have not given enough pain relief. It is unlikely that any medication will completely take away my pain, but for humane reasons, narcotic pain medication will be given to me as long as pain continues, provided that I follow the terms and conditions of this agreement. I understand that the possible complications of chronic narcotic therapy include:

- Chemical dependency (addiction)
- Constipation, which could be severe enough to require medical treatment
- Difficulty with urination
- Drowsiness
- Nausea
- Itching
- Slowed respiration
- Reduce sexual function

If I take more medication than what I was prescribed, a dangerous situation could result such as comma, organ damage or even death. I understand that if I run out of medication too soon, or if my medication is stopped suddenly, I could have narcotic withdrawal symptoms, which can be very uncomfortable or dangerous. If I become pregnant there are known or unknown risks to unborn child which includes narcotic addiction and the possibility of the baby experiencing narcotic withdrawal at birth. I am obligated to let my doctor know if I am pregnant and they will help me find ways of controlling my pain without narcotics.

The term of this contract include the following:

1. Only one pharmacy will be used for filling narcotic prescription: The pharmacy you have selected is _____ Phone _____
2. If it is found that I received a prescription for narcotic medications from a source other than **Med-Care Providers LLC**, I will be discharged from **Med-Care Providers LLC** and any prescription for narcotic medication will be discontinued.
3. It is necessary to call **Med-Care Providers** Monday through Friday (9:00 am - 5:00 pm to refill medications. It is important to make sure that I have enough medication to get through the weekend or after hours.
4. The physician/provider on-call or after hours on weekends will **NOT REFILL** my medication. They do not have charts available for review to make decisions regarding medication.

5. I agree and will sign a release to **Med-Care Providers** to communicate with my referring physician, primary care physician and pharmacists regarding my use of medication.
6. I will contact and communicate with **Med-Care Providers** about narcotic and pain related side effects. I would **NOT** contact a physician/provider who does not work for **Med-Care Providers** regarding the above concerns. If I have significant side effects that occur after hours or during the weekend, it is appropriate to go to the emergency room at the nearest hospital.
7. I agree to take the narcotic medication, exactly as instructed by my **Provider** at **Med-Care Providers.** I am **NOT** allowed to change the dosage amount or alter the time schedule of taking the medication without talking to my **Provider** at **Med-Care Providers**.
8. I agree that **Med-Care Providers** will not replace any lost, stolen, or inaccessible narcotic medication or narcotic prescription for any reason.
9. I must keep all regular follow-up appointments as recommended by **Med-Care Providers**. Failure to comply may cause discontinuation of narcotic prescription and possible discharge from **Med-Care Providers**.
10. **Med-Care Providers** will not accept telephone requests for narcotic prescriptions or refills from anyone other than me.
11. All narcotic prescriptions will be picked up by me. If I am too disabled or sick, an exception may be allowed at the discretion of my Provider at **Med-Care Providers**.
12. I understand that the benefits of narcotic medication will be evaluated regularly using the criteria of pain relief:

    a. Increase in general function
    b. Increase in life activities
    c. Improvement in pain intensity levels
    d. Absence of unacceptable side effects
    e. If appropriate, possible return to work and maintenance of job

13. I agree to periodic urine screenings for the medication and drugs if **Med-Care Providers** deems appropriate
14. I have given information about the use of narcotic medication and possible risk of side effects including development of tolerance, dependence, addiction and withdrawal problems due to medications, and I agree to undergo narcotic administration.
15. I agree to **NOT** hoard medication or alter narcotic prescription. These behaviors and other unacceptable behaviors will result in discontinuation of narcotic prescription and possible discharge from **Med-Care Providers**.
16. I agree to the following:

a. That I am **NOT** currently abusing illicit or prescription drugs and that I am not undergoing treatment for substance abuse.
b. That I never was involved in the sale, illegal possession or transport of any drugs.
c. **Women only**: That I am **NOT** pregnant and will inform my physician/provider if I become pregnant.

This Form has been fully explained to me, I have read it, or I had it read to me and I understand and agree to the terms of this contract. If any part of this contract, as outlined above, is broken, I understand that it will result in immediate discharge from **Med-Care Providers** and discontinuation of narcotic prescriptions.

Patient Name: _____DOB_____

Patient Signature _____Date_____

Physician/Provider/Witness name: _____

Signature:_____