Consent and Contract for Controlled Substances

Please read this form entirely. If contains information to assist you in making a decision to have a specific therapy. Initial each paragraph if you understand it. If you do not understand it, do not initial it and each paragraph will be discussed with you separately. There are risks and complications that may result from this therapy, they are rare, but do exist and you must be aware of them.

The purpose of this agreement is to prevent misunderstandings about certain medications you will be taking. This agreement is to help you and your provider to comply with the law regarding controlled pharmaceuticals.

\_\_\_\_\_ I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

\_\_\_\_\_ I understand that this agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this agreement.

\_\_\_\_\_ I understand that if I break this agreement, my provider will stop prescribing these pain control medicines.

\_\_\_\_\_ In this case, my provider will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

\_\_\_\_\_ I would also be amenable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems necessary.

\_\_\_\_\_ I will communicate fully with my provider 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.

\_\_\_\_\_ I will not use any illegal controlled substances, nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to times when I am not driving or operating machinery and will be infrequent.

\_\_\_\_\_ I will bring all unused pain medicine to every office visit.

\_\_\_\_\_ I agree to submit to random blood or urine tests to determine my compliance with my program of pain medicines. You will be required to pick up an order and go to the lab to submit a specimen within 24 hours of notification.

\_\_\_\_\_ I will not share my medication with anyone.

\_\_\_\_\_ I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider.

\_\_\_\_\_ I will safeguard my pain medication from loss, theft, or unintentional use by others, including youth. Loss or stolen medications will not be replaced.

\_\_\_\_\_ I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

\_\_\_\_\_ I agree to use one primary pharmacy for filling my prescriptions for all of my pain medicine. This designated pharmacy is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_located at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_ Your active treatment plan has the following goals:

1. Pain control (Not the absence of pain)
2. Improved function for regular exercise and reasonable activities
3. Available specialty consultation upon request by you and your HCP

\_\_\_\_\_ Your addiction Risk Assessment (ORT score) is:\_\_\_\_ Low, Moderate, High

\_\_\_\_\_ If I am pregnant or intend to get pregnant, I am required to notify my clinician, immediately to discuss tapering off stimulants that could potentially harm the fetus. I understand that failure to do so may result in discharge from the clinic. I will not hold the clinic responsible for any harm that may occur to me and/or my unborn.

\_\_\_\_\_ I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state’s board of pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my provider to provide a copy of this agreement to my pharmacy, primary care provider and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

\_\_\_\_\_ I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of pain control medications.

\_\_\_\_\_ I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program website periodically throughout my treatment period.

\_\_\_\_\_ I agree that I will use my medicine at a rate no greater that the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I have read the foregoing information, it has been explained, and I understand it. All of my questions have been answered. By executing this form, I am indicating that I no questions whatsoever and I give my full informed consent to have a CONTROLLED SUBSTANCE prescribed.

Medications Lists that is covered under this agreement:

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Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HCP Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_