SPORTS ORTHOPEDIC ADVANCED REHABILITATION, LLC

CONTROLLED SUBSTANCE PRESCRIPTION AGREEMENT

I, _____(DOB: _____), am a patient under the care of Dr. Teresa Gurin and have agreed to use opioids as part of my treatment for pain. I understand that these drugs are very useful, but have a potential for misuse and are thereby closely controlled by the local, state, and federal governments. Because my physician is prescribing such medication to help manage my pain, I agree to the following conditions. The risks, side effects, and benefits have been explained to me**. I am aware that failure to abide by any of these conditions will be considered a breach of contract. If this happens, my physician will withdraw all prescriptions and I will be discharged from all care at this clinic.**

____ 1. **I understand the medication must assist me to function better.** If my activity level or general function gets worse, the medication will be changed or discontinued.

____ 2. **I am responsible for my pain medication.** I agree to take medication only as prescribed and to contact my physician at this clinic before making any changes.

____ 3. **I will participate in other treatments** (which can include other medication and/or non-medications) which my doctor recommends. I will be ready to taper or discontinue the controlled substance medication, as other effective treatments before available. I also agree to bring any unused medications into the clinic at my physician's request.

____ 4. If I have another condition that requires the prescription of a controlled substance medication (narcotics, tranquilizers, barbiturates, or stimulants) or if I am hospitalized for any reason, I will inform Dr. Gurin within TWO BUSINESS DAYS.

____ 5. **I will not increase my dosage without approval from my doctor.** I understand that increasing my dose without the close supervision of my physician could lead to a drug overdose, causing severe sedation, respiratory depression, and even death.

____ 6. **I will not stop taking my medication without my doctor's supervision.** I understand that decreasing or stopping my medication without the close supervision of my physician could lead to withdrawal. Withdrawal symptoms may include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot or cold flashes, "goose flesh," abdominal cramps, and diarrhea. These symptoms can occur 24-48 hours after the last dose and can last up to 3 weeks.

____ 7. **I will not accept controlled substances from any other doctor.** Dr. Gurin will be the only physician from whom I will receive any narcotic/opioid medication. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician at this clinic.

____ 8. **I understand the side effects that are related to opioid medication.** I understand while on these medication(s) I may experience common side effects of nausea and vomiting (similar to motion sickness), drowsiness, and constipation. Less common side effects are mental slowing, depression, flushing, sweating, itching, urinary difficulty, low blood pressure, slow heart rate, allergic reaction, respiratory depression and jerkiness. These side effects would occur at the beginning of treatment and often go away within a few days. It is my responsibility to notify my physician of any side effects that continue or are severe (such as sedation or confusion). I am responsible for notifying my physician immediately if I need to visit another physician or emergency room due to side effects or pain.

____ 9. **I will notify my physician if I am contemplating pregnancy or if I become pregnant.**

____ 10. **I understand that the opioid medication is strictly for my own use.** The opioid should never be given to others under any circumstances. If children are in the house, a childproof cap is necessary.

____ 11. **I understand that I must contact my physician before taking other medication including over-the-counter medication.** I will contact my physician before taking benzodiazepines (drugs like Valium or Ativan), sedatives (drugs like Ambien, Soma, Xanax, or Fiorinal), and antihistamines (drugs like Benadryl). I understand that the combined use of the above drugs and opioids may produce profound sedation, respiratory depression, and even death. I will not consume alcohol or use recreational drugs while on opioids. If consumed, the consequence may be termination of treatment by this clinic.

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____ 12. **I understand that patients with a history of drug or alcohol abuse are at a high risk of relapse from certain medications.** I have notified this clinic of any personal or family history of substance abuse, including alcohol.

____ 13. **I will see my doctor on a regular basis.** I will see my physician at least every 3 months. If I can not come to the visit I will call and reschedule. Prescriptions will not be refilled if I am not seen in the clinic for over 4 months. It is my responsibility to schedule and keep all appointments.

____ 14. **I am responsible for my opioid prescriptions.** I understand that refill prescriptions:

1. Can only be written for more than a 1-month supply.
2. Will always be filled at the same pharmacy (listed below)
3. Shall be made during regular office hours: Monday through Friday from 8 a.m. to 4:00 p.m. **Refills will not be made at night, on weekends, or on holidays.**
4. **Will not be replaced or filled early. No exceptions will be made,** even with lost, stolen, or misplaced prescriptions.
5. I must call at least 3 working days ahead to schedule pickup of my prescriptions.

____ 15. **I will call my doctor if I feel I am becoming tolerant to my medication.** While physical dependence is to be expected after long-term use of opioids, signs of addiction may be interpreted as a need for weaning and detoxification.

____ 16. **I understand that my goal is to relieve my pain.** My pain physician's goal and my goal are to reduce and relieve my pain. I understand that the treatment plan may include time-contingent use of opioids. If it appears to the physician that there is no improvement to my daily function or quality of life from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed by my physician.

____ 17. **I understand that I must submit to random urinalysis.** I agree to submit to urine and blood screens at any time as determined by my physician to detect the use of both prescribed and non-prescribed medication. I will be charged a fee, payable at the time of urine screening, for this testing.

____ 18. **I understand that I must follow all of the above rules or be subjected to dismissal of care by this clinic.**

____ 19. **I authorize this clinic to contact my pharmacist at any time with questions or concerns about any medications that I am receiving/taking.** I authorize my pharmacist to speak to my doctor at this clinic concerning my medications.

____ 20. **I understand that state law prohibits driving a motor vehicle or operating dangerous equipment while taking sedating medication.** If I choose to drive a motor vehicle while taking a narcotic medication, I can be charged with DUI, and if I am involved in an accident, I may be found at fault. It does not help or matter if my doctor believes it was safe for me to drive.

____ 21. **I understand that this clinic fully cooperates with all law enforcement agencies.** If I violate this contract, this clinic staff **MUST** consider that I may be abusing or selling medications. This clinic will report such activities to the appropriate law enforcement agencies. In this instance, doctor-patient confidentiality does not prevent doctors from providing pertinent information to law enforcement agencies.

____ 22. **I understand that dishonest or disrespectful behavior will not be tolerated at this clinic and will result in immediate discharge from this clinic.** Examples include profane, disrespectful or aggressive language, and aggressive behavior or threats.

I have read the above information (or it has been read to me), and all of my questions regarding treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in opioid medication therapy.

Patient's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Pharmacy's name, city and telephone number: _____

Developed October 16, 2009