**Patient Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Long –Term Controlled Substances Therapy for chronic Pain Agreement**

***(A consent form from the American Academy of Pain Medicine)***

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long –term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long – term benefits. There is also the risk of an addictive disorder developing or of a relapse occurring in a person with a prior addiction. The extent of this risk is uncertain.

Because patient use of these drugs has potential for abuse or diversion, strict accountability is necessary when patient use is prolonged. When the doctor, whose signature appears at the last page, is willing to consider the initial and/or continued prescription of controlled substances to treat your chronic pain, this agreement will only be subject to your strict adherence to the following policies indicated below:

1. **All controlled substances** must come from the physician (whose signature appears on the last page), or during his/her absence, by the covering physician, unless specific authorization is obtained for an exception. Multiple sources can lead toward (*unfavorable*) drug interactions or poor coordination of treatment.
2. **All Controlled Substances** must be obtained at the **same pharmacy** when possible. Should the need arise to change pharmacies, our office must be informed. Please indicate below, the pharmacy or pharmacies you have selected.

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1. You are expected to inform our office of any new medications or medical conditions, and of any adverse (*unfavorable*) effects you experience from any of the medications that you take.
2. The prescribing physician has permission to discuss all diagnostic and treatment details with the dispensing pharmacists or other professional who provide your healthcare for purposes of maintaining accountability.
3. You may **NOT SHARE**, **SELL** or otherwise permit others to have access to these medications.
4. These drugs should not be stopped abruptly, as an ***abstinence syndrome*** will likely develop.
5. Prescriptions and/or containers of these medications may be sought by other individuals with a chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication(s) and prescription. They should **NOT** be left out where others might see or otherwise have access to them.
6. Original containers of medication should be brought into the office only if requested by your doctor.
7. Since these drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such persons.
8. Medications **MAY NOT BE REPLACED** if they are lost, become wet, are destroyed, left on an airplane, etc. You must immediately file a police report preferably with the police department in the area where the medication or prescription was lost or stolen. Obtain a police report number, along with the police officers name and contact number, before your doctor can make a decision to replace the lost or stolen item.
9. **EARLY REFILLS** will generally not be given (most controlled medications are prescribed on a 30-day basis).
10. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they will not be filled prior to the appropriate date.
11. If the responsible legal authorities have questions concerning your treatment, as might occur, for example; if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
12. It is understood that failure to adhere to these policies may result in cessation of therapy with the controlled substance prescribed by this physician or referral for further specialty assessment.
13. Renewals are contingent on keeping scheduled appointments. **WE DO NOT** **phone in prescriptions after hours or on weekends.**
14. It should be understood that any medical treatment is initially a trial, and that the continued prescription of the medication(s) is contingent on evidence of benefit.
15. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation).
16. I understand the risk of Opioids and sedatives including but not limited to: Nausea, Vomiting, Itching, Constipation, and Urinary retention, Respiratory, Depression, Allergic Reaction and Death.
17. I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , understand and agree by signing this agreement that if requested by the

 (**Patient Name**)

 Doctor(s): **DR HERSEL**, or **DR OKHOVAT**, or **DR LEE**, or **DR SPIEGEL**,

 **I authorize Pain Management and Injury Relief Medical Center**  to perform unannounced urine or serum toxicology screen(s) if the doctor deems necessary.

 I also understand my cooperation regarding this matter is required.

 Presence of an unauthorized substance(s) may prompt referral for assessment for an addictive disorder and

 discharge from this office.

1. You affirm that you have the full right and power to sign and be bound by this agreement, and that you have read, understood and accepted all of its terms.

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**Physician Signature Patient Signature**

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**PRINT Physician Name PRINT Patient Name**

**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_