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Pain Management Narcotic Agreement (Page 1 of 2):

Our goal in the field of pain management medicine is to assist patients with the treatment of their chronic pain. We achieve this goal through various modalities, including injections or nerve blocks, physical therapy, exercise programs, psychological counseling when needed, and referrals to surgeons or other specialists as required. We strive to manage pain through means other than medications to allow patients to live a relatively pain free life. We seek to treat the cause of pain and not the symptoms. **However, we also understand that strong narcotic analgesic and other prescription medications may be indicated for the treatment of certain chronic pain conditions.**

The purpose of this agreement is to clarify the conditions under which the pain management doctor will prescribe medication stop you. The agreement will help you and your doctor comply with the laws regarding controlled pharmaceuticals and prevent misunderstandings about the medicines you may take for your pain condition. **Please read each item in this agreement very carefully.**

I understand and agree to the following terms of all prescriptions:

(Please initial below)

1. _____ I will use my medications at a rate no greater than that prescribed by my pain management physician. If I do over-use my medication, that medication will not be refilled early, and I may be without pain medication for some period.
2. _____ I will not share, sell, or trade my medication with anyone. I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor. I will safeguard my written prescriptions and pain medicine from loss or theft. I understand that lost or stolen written prescriptions or medicines will not be replaced.
3. _____ Sudden discontinuation of narcotic pain medication may lead to unpleasant or dangerous withdrawal symptoms.
4. _____ If my physician feels that my dose of pain medication is excessive or makes the diagnosis of addiction, he/she will reduce the medicine over a period (days, weeks, months) as necessary to avoid withdrawal symptoms. Also, a drug-dependence treatment or detoxification program may be recommended.
5. _____ I understand and agree that I am not to receive any prescription pain medication or sedative medication from any physician other than my pain management physician unless there is a specific medical necessity. Should my caregiver or I receive any pain or sedative medications from any other physician, my caregiver or I must inform the pain center either by telephone or in writing within 72 hours of having filled the prescriptions.
6. _____ Refills of my prescriptions will be issued only during regular office hours.
7. _____ Refills will not be available during evenings, on weekends, or holidays, and without at least 72 hours' notice to the physician or their office staff.
8. _____ I understand that it is my responsibility to keep track of my supply of medication.
9. _____ I will communicate fully and truthfully with my doctor 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 understand that I, or my caregiver, is responsible for the information given to the physician.

Pain Management/Narcotic Agreement (Page 2 of 2) continued:

10. _____ I have been advised to abstain from or significantly moderate my use of **alcoholic beverages** while taking medication for my pain condition. I will not use any illegal or controlled substances, including but not limited to marijuana, cocaine, heroin, ecstasy, GHB, etc. If I am a **cigarette smoker**, I understand that I will be asked to quit. Cigarette smokers typically have decreased response to pain treatment because of the effects of smoking on oxygen delivery to peripheral tissues. Additionally, **obesity** is one of the most important causes for failed treatment for chronic pain. Every ten pounds of excess weight that one carries on the spine, vertebral discs, and spinal nerves. Excessive weight will therefore result in an increase in pain. If you are overweight, you will need to enroll in a weight loss program. Physical therapy will also be directed to this area as well.
11. _____ If physical therapy is prescribed, I agree to attend and fully participate as possible. If there are any problems with my physical therapy, I agree to communicate this to my physician so that he or she can make the appropriate changes in my therapy program.
12. _____ I agree that I will submit to a blood, urine, or saliva test if required by my doctor to determine my compliance with my regimen of pain medication. These tests confirm that I am following the treatment exactly how my provider has ordered. I understand I may be required to come to the office at short notice to complete these required tests if necessary. I understand that not following these requirements may result in my provider not sending my prescription.
13. _____ If requested, I will bring all unused pain medicine to an office visit for a "pill count". My physician may request additional "pill counts" at any time, and I agree to comply with these requests. I agree that I will bring the most recent prescription container for each medication to each visit with my physician. These containers must correspond to the last prescription recorded in the medical record with the prescription labels intact and legible so that the physician in the medical record may document appropriate control information, specifically, the prescription registration number and pharmacy telephone number will be noted and verified.
14. _____ I further understand that this agreement is essential to the trust and confidence necessary in a doctor-patient relationship and that my doctor undertakes to treat me based on this agreement. I understand that if I break this agreement or provide any false information, my doctor will stop prescribing these pain-control medicines and I may be immediately removed from the doctor's care.

I have reviewed all the items contained in this 2-page agreement. I agree to follow all the guidelines that are described above. All my questions and concerns regarding treatment have been adequately answered. A copy of this document will be given to me upon request. I voluntarily consent to participate in the pain medication program described in this agreement.

Patients' Signature: _____ **Date:** _____

Patient Representative Name: _____ **Patient Representative Signature:** _____

Witness: _____
