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Opioid (Narcotic) Contract

The purpose of this agreement is to prevent misunderstandings about certain medications you will take for pain management.

I understand that if I break this Agreement, the Provider will stop prescribing these pain-control medicines. In this case, the Provider will taper off the medicine over a period of several days, if necessary, to avoid withdrawal symptoms. Also, a drug dependence treatment program may be recommended.

- I will communicate fully with the Provider about the character and intensity of my pain, the effects of the pain on my daily life, and how well the medicine is helping to relieve the pain. **Initials _____**
- I understand that narcotic and controlled drug prescription is My Responsibility. I understand that if anything happens to this prescription (i.e. it is lost, stolen, flushed down the toilet, etc.), I am personally responsible and the Provider will not rewrite the prescription until the designated time is given; **Initials _____**
- I will not use any illegal substance (Heroin, Cocaine, Amphetamines, Phencyclidine, etc.) **Initials _____**
- I will not share, sell or trade my prescription and/or medication with anyone. **Initials _____**
- I will not attempt to obtain any controlled medicines, including steroid pain medicines, controlled stimulants, or anxiety medicines from any other doctor. I will communicate with my Primary Care Physician that I have signed a Opioid (Narcotic) Contract with my Pain Management Physician and/or Physician Assistant. **Initials _____**
- I will safeguard my pain medicine. I understand that this medication may be lethal or hazardous to a person that is not tolerant to its affects, especially a child. **Initials _____**
- I agree that refills on my prescriptions of pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or weekends. No refills will be phoned into the pharmacy. I understand that it is my responsibility to schedule my appointments in accordance to when my medications will be due for refill and 72 hours notice should be given to my provider before a refill is needed. I will receive medications at the intervals determined by my provider. **Initials _____**
- I authorize my doctor and 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 medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. I also agree to only use one pharmacy. **Initials _____**
- I understand the possible adverse effects and dependencies associated with my medication. Overdose of medication may result in injury or possible death. Other side effects may include, but are not limited to constipation, difficulty in urination, fatigue, drowsiness, nausea, itching, loss of appetite, confusion, sweating, flushing, sexual dysfunction, and or depressed respiration. I understand that there is a possibility of impairment of thought processes, especially if a narcotic is combined with a sedative, a sleeping pill, tranquilizer, or alcohol. **Initials _____**
- I agree that I will submit to a urine test when requested by my Provider to determine my compliance with my program of pain control medicine. Additionally, I agree to bring my medication to each visit for use in random pill counts. Refusal of such testing or positive results will result in prompt termination of care. **Initials _____**
- I understand that altering a prescription in any way is against the law and a violation will be reported to the appropriate authorities; **Initials _____**
- I understand that I am expected to inform my Provider of any new medications or medical conditions, and of any adverse effects I experience from any of the medications being prescribed. **Initials _____**
- I understand that if I plan to become pregnant or become pregnant, I have to inform the Provider. I understand that if I become pregnant, a child will likely be physically dependent at birth if I continue narcotics. **Initials _____**
- I realize that it is my responsibility to keep others and myself from harm, including safety of driving and the operation of machinery. **Initials _____**
- I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in me being without medication for a period of time. **Initials _____**

All of my questions and concerns regarding treatment have been adequately answered. A copy of this Agreement will be given to me and to any physician with whom I seek treatment from.

PATIENT NAME _____

PATIENT SIGNATURE _____ DATE:_____