Family Medicine Associates

Narcotic Drugs Agreement for Chronic Pain Management

Narcotic drugs may be prescribed to treat chronic (long-lasting) pain. However, because narcotic medicines have a high potential for abuse or misuse, they are tightly controlled by local, state, and federal laws. For this reason, patients taking narcotic medicines for longer than 90 days must sign this controlled substance agreement in order to continue receiving these medicines from Family Medicine Associates.

I, _____, agree to the following:

1. The goal of narcotic treatment is not to completely eliminate pain, but only to improve a quality of life by increasing the ability to function and work.

2. Common side effects of narcotic therapy include constipation, nausea, sweating and itchiness. I agree to report any side effects that are persistent or bothersome to my medical provider. Drowsiness may also occur when starting or increasing the dose of narcotic medicine. I agree not to drive a vehicle, operate heavy machinery, or perform other dangerous tasks until drowsiness has subsided.

3. I understand that the risk of side effects may be increased when this medicine is combined with alcohol, other depressants, or illegal drugs.

4. I agree to notify my medical provider of the use of any substances, including alcohol, tranquilizers, marijuana, and other illicit drugs. I consent to random drug screens and pill counts, which may be ordered at any time during my treatment. I understand that the confirmed use of illicit drugs or refusal to submit to drug screens or pill counts may result in the discontinuation of narcotic therapy.

5. My medical provider and I will continually evaluate the effectiveness of narcotic therapy in achieving the treatment goals; changes will be made as needed. I agree to take the medicine at the dose and frequency prescribed by my medical provider. I understand that increasing the dose of this medicine without my provider's approval may result in a discontinuation of treatment.

6. I will attend all appointments, follow-ups, and consultations as requested by my medical provider. Failure to attend sessions or reschedule cancellations will result in the discontinuation of narcotic therapy.

7. I understand that my medical provider will not adjust my narcotic prescription over the phone. My provider will only renew prescriptions at regularly scheduled follow-up appointments. I will not seek narcotic medicine from another provider and I will have all narcotic prescriptions filled at _____ pharmacy.

8. I understand that if my prescription runs out early for any reason (such as losing the medicine or using more than prescribed), my medical provider will not prescribe extra narcotic medicine to me. I will have to wait until the next prescription refill is due.

9. I will not share, trade, or sell my medicine to anyone else, including family members; nor will I accept narcotics from others. I agree to be responsible for the secure storage of my medicine at all times. In the event the medicine is stolen, I will report the theft to the police and provide my medical provider with a police report of the event.

10. I understand that I may become addicted to narcotic medicines. I authorize my medical provider to discuss my pain management with other health care professionals and family members when it is deemed necessary. This includes permission for my medical provider to refer me to an addiction specialist as a condition of narcotic therapy. If narcotic therapy is discontinued for any reason, I understand that my medical provider will coordinate a narcotics withdrawal plan, which may involve other health care specialists.

Failure to adhere to the agreement outlined above will result in discontinuation of narcotic therapy for chronic pain and dismissal from this medical practice. By signing this contract, I assert that all my questions have been answered, that I understand the terms of the agreement, and that I have not been coerced in any way. A copy of this contract will be made available for review.

This agreement is entered into effect on this _____day of _____, 20_____.

_____ _____

Patient Medical Provider

_____

Witness

I acknowledge receipt of a copy of this Agreement on the date stated above.

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