Controlled Substances Agreement for:

Patient Name: ___________________________________ **Birth Date:** ___________________

This *Controlled Substance Medication Agreement* allows you and your physician to work together in good faith, and for you to understand the importance of these medications. A "***controlled substance medication", or CSM***, is a drug or chemical that is government regulated because of its illegality for sale or use when not prescribed by a physician. In prescribing a CSM, we partner with you to create the best treatment plan for your improvement and management of pain. This requires cooperation, trust, and mutual respect. If you cannot agree to the following terms, we will be unable to prescribe controlled pain medication for you. Failure to follow all terms will result in discontinuation of the pain medication and/or dismissal from our practice.

1.	I understand the risk of psychological and/or physical dependence and addiction associated with chronic use of CSMs.
2.	I understand that this practice may prescribe a CSM as part of my treatment plan for post-operative pain management. The CSM won't be prescribed for long-term pain control, and will cease at 12 weeks post-op.
3.	I will take the medication exactly as prescribed and I will not change the medication dosage and/or frequency without approval of my surgeon/physician managing pain. Use of my medication at a greater rate will result in my being without medication for a period of time.
4.	I will keep regularly scheduled appointments with my surgeon. There may be times when my medications need a refill between office visits. If that occurs, call our staff at least 1-2 days before the medication runs out. Refill requests are ONLY taken Monday-Thursday, 8am – 4pm, and Friday, 8am-Noon. Requests for CSMs after Noon on Friday WILL NOT be considered for refill until Monday morning at 8am. My physician or an on-call physician may not refill CSMs after hours or on weekends.
5.	The CSM prescribed is being given to control pain, improve function, and complete post-operative exercises. If there are any changes to my activity level or physical condition, the treatment may be changed. I am responsible for notifying my surgeon and this practice of such changes.
6.	I will taper or discontinue the CSM as my condition improves. My surgeon will not prescribe narcotics pre-operatively or past the 12 week post-operative date. My surgeon may recommend further work-up if I still require narcotics past 12 weeks. If the work-up is negative, I will be referred to a pain management specialist for management of my pain medications.
7.	I am willing to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems it necessary.
8.	I will not accept or seek CSMs from any other healthcare provider outside of this practice while my physician prescribes me pain medication. If I already have a pain management physician, they will need to be included in my post-operative pain management and will be the party responsible for managing my pain above and beyond normal post-operative medications.
9.	If I have another condition that requires the prescription of a CSM (narcotics, tranquilizers, benzodiazepines, barbiturates, or stimulants), I will coordinate all medications with that prescribing physician, including any pain medication for my orthopedic condition.
10.	It is required that I use a single pharmacy for all prescriptions. I may use a chain of pharmacies with different branches as the prescription information is available at all branches. This is required to make certain that my medications are known by a pharmacist able to evaluate any concerns about interactions of medications.
11.	I understand that lost, stolen, or misplaced prescriptions or pills WILL NOT be replaced. All patients are required to act responsibly with their medications. To allow others to use my pain medication is illegal and dangerous. This type of behavior won't be tolerated by my surgeon or this practice.
12.	I agree that I will not use any other illegal/recreational drug or alcohol while receiving pain medication from this practice, and that use of said items, especially while taking pain medication, is extremely dangerous and potentially lethal.
13.	I will not use narcotic medication while driving or operating machinery as it poses a serious safety threat to me and others.
14.	I authorize my provider 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 medication. I authorize my provider to give a copy of this Agreement to my pharmacy, primary care provider, and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
15.	I agree to follow these guidelines that have been fully explained to me. All my questions and concerns regarding treatment have been adequately answered.

Signature of Person Signing Agreement: ____ Date: ____________________

If person signing Agreement is not the patient, please print your name and list relationship to patient:

Name ____ *Relationship* ______________________