



Patient Name:	
Date of Birth:	

Long-Term Controlled Substances Therapy for Chronic Pain

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

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed upon by the below-signed patient, as consideration for, and a condition of, the willingness of a S.E. PA Pain Management provider to consider the initial, and/or continued prescription of controlled substances to treat your chronic pain.

1. All controlled substances must come from a S.E. PA Pain Management provider unless specific authorization is obtained for an exception. [Multiple sources can lead to untoward drug interactions or poor coordination of treatment.]
2. All controlled substances must be obtained at the same pharmacy, whenever possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that I have selected is:
_____ Phone: _____
3. I understand, I am expected to inform S.E. PA Pain Management office within a week of any new medications or medical conditions, and of any adverse effects I experience from any of the medication that I take.
4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability.
5. I will not use any illegal controlled substances, including marijuana, cocaine, etc. I will not share, sell, or trade my medications with anyone. I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctors without prior notification and approval by a S.E. PA Pain Management physician.
6. I agree that refills of my prescriptions for pain medicine will be made only at the time of a scheduled office visit. No refills will be available during evenings or on weekends. Renewals are contingent upon keeping scheduled appointments.

7. I understand that these drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
8. I understand I am required to cooperate with all unannounced and/or routine urine, saliva or serum toxicology screens that are requested by S.E. PA providers. Presence of unauthorized substances may prompt referral for assessment for addictive disorder and discontinuation of care by S.E. PA Pain Management.
9. Original containers of medications will be brought in to each office visit.
10. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially children, I understand the importance of keeping them out of reach of such people.
11. Medications may not be replaced if they are lost, get wet or are destroyed, etc. If medication is stolen, I understand a police report must be filed and provided to S.E. PA for an exception to be considered.
12. Prescriptions may be issued early if the provider or patient will be out of town when a refill is due, at the discretion of the S.E. PA provider. These prescriptions will contain instructions to the pharmacist that they should not be filled until the appropriate date.
13. I waive my right to confidentiality, specific to my controlled substance prescriptions and administration, if S.E. PA is approached by law enforcement authorities.
14. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by S.E. PA providers or referral for further specialty assessment.
15. I understand that all medical treatment is initially a trial, and that continued prescription is contingent upon evidence of benefit.
16. I understand the risks and potential benefits of these therapies.

By signing below, I affirm that I have read this agreement and understand and agree to all the terms as stated above.

Provider Signature

Patient Signature

Date

Date