Patient name: _____
Date of birth: _____

PAIN MEDICINE ASSOCIATES

CONTROLLED SUBSTANCE PAIN MANAGEMENT AGREEMENT

The treatment of chronic pain sometimes involves the use of narcotics (opiates) or other controlled medications. This is typically the case when other medications have failed to properly control the patients' pain and when other treatment modalities have either not been effective or are not reasonably available for use.

These medications are controlled substances and are therefore closely monitored by local, state and federal agencies. While these medications may be highly effective when taken as directed under medical supervision, these medications carry significant risks. The potential for PHYSICAL DEPENDENCE and ADDICTION is very HIGH. Opioid dependence during pregnancy is associated with increased risk of low birthweight, neonatal mortality, and maternal complications.

PHYSICAL DEPENDENCE is almost certain with any extended daily use of narcotics or other controlled substances. Physical dependence is easily differentiated from addiction. Discontinuation of medications to which one is physically dependent may produce:

1. Agitation
2. Nausea/vomiting
3. Sweating/flu-like symptoms
4. Seizure/death particularly with benzodiazepine medications
5. Increased pain

Addiction involves an abnormal social behavior to obtain medications, such as stealing, lying, or abusing the medications prescribed.

COMPLICATIONS of chronic narcotic therapy include but are not limited to

1. Constipation
2. Nausea/vomiting
3. Drowsiness/sedation
4. Impaired ability to drive or operate machinery
5. Difficulty with urination
6. Reduced sexual function
7. Potentially osteoporosis, dental decay, reduced response to stress
8. RESPIRATORY DEPRESSION /DEATH

A major goal of chronic narcotic therapy is not just the relief of pain, but an improvement in the patients' ability to function. We expect our patients to participate in questionnaires, physical assessment, or other measuring tools which may be required to gauge proper response to therapy. We expect our patients to participate in physical therapy when indicated, an exercise regimen where prescribed and to be able to document their participation.

Psychological assessment may frequently be required and we expect our patients to readily participate. Failure to attend initial psychological screening or suggested follow-up visits may necessitate discontinuation of the medical management option.

The physicians, nurse practitioners and physician assistants of Pain Medicine Associates treat many people with chronic painful conditions. We may be willing to prescribe controlled substance in certain select cases for the control of pain. The type of medication, dose of medication and frequency of medication must be under our control. We are charged by the State of Tennessee and the Federal Government to employ all reasonable means to limit any opportunity for medication diversion. Medication abuse and/or diversion for resale is a very important problem to which we REFUSE TO CONTRIBUTE.

Patient name: _____
Date of birth: _____

EACH PATIENT receiving controlled substances/narcotics from Pain Medicine Associates MUST ABIDE by the following rules.

1. ____The providers of Pain Medication Associates will be the only provider of narcotic pain medication. I am not permitted to obtain such medication form any other doctor or provider unless authorized by Pain Medicine Associates. If an emergency or different pain problem occurs and I receive a narcotic medication from another provider, clinic or emergency room then I will notify Pain Medicine Associates as soon as I am able.
2. _____I understand that certain medications may interact with others; therefore, I agree to inform Pain Management Associates of ALL medications I am taking for any reason. I agree to update them if any changes are made to my medications.
3. _____I agree to bring any and all medications from ALL prescribers to my appointments as requested.
4. _____I understand that a psychological assessment may be requested and updated in the future. I agree to participate in psychological testing, treatment and updates as requested.
5. _____I agree to comply with all physical therapy, exercise regimens or other treatments recommended.
6. _____I understand that drug tests may be performed either at random or to address a specific concern. The timing or such drug tests will be at the sole discretion of the providers of Pain Medicine Associates. I understand that the use of illicit substances such as cocaine, marijuana is prohibited. I also understand that the use of alcohol, while legal, may dangerously interact with my medications and will be avoided. I agree to comply and understand that failure to comply may result in discontinuation of narcotic medical management.
7. _____I understand that I may be "called in" to appear at the offices of Pain Medicine Associates for a random/non-random drug screen and medication count and I agree to comply. I understand that failure to appear may result in discontinuation of my opportunity for controlled substance medical management.
8. _____I understand that all medications must be taken as prescribed. I understand that medication adjustments are made only in the office setting and I agree I will not alter my medication dosing without specific approval.
9. _____I understand that my medications are to be utilized by myself only and I agree not to "share" my medications with any one else.
10. _____I understand that prescriptions are provided only at appointments. I understand that if I take my medications more often than prescribed then I will "run out" early and that medications will NOT be filled early. I understand that it is my responsibility to ensure that I leave the office with an appointment consistent with my medication supply.
11. _____I understand that I am responsible for my prescriptions and medications and that neither will be replaced should they be lost, misplaced or stolen.
12. _____I agree to report stolen medications to the police and to provide a police report to the office regarding the incident. I also understand that stolen medications with or without a police report will not likely be replaced.
13. _____I understand that controlled substances may be very harmful to me and to others and I accept the responsibility for securing my medications in a locked safe or cabinet to prevent theft and to prevent access to children and other adults who might be harmed by their use.
14. _____I understand that my medication utilization may be monitored by multiple means including utilizing various states pharmacy databanks; provider records etc. and I readily consent to such monitoring and contact with and informing other medical providers as deemed necessary.
15. _____I agree to obtain all prescriptions for controlled substances from a single pharmacy. That pharmacy is _____ at telephone number _____.
16. _____I understand that altering or forging a prescription is a crime. I understand that selling controlled substance medications is a crime and I agree to do neither. I also understand that either action may result in criminal action.
17. _____I understand that the continued provision of controlled substance medications through the providers of Pain Medicine Associates is solely at the discretion of the providers. I understand that Pain Medicine Associates is under no obligation to continue medication and that they have the right to decrease or discontinue my pain medications at any time strictly at their discretion.
18. _____I understand that my compliance with the above policy statements/agreements is necessary for my continuation in the medical management of my disease. I understand that these agreements are not intended to represent any adversarial relationship but are simply an attempt to allow access to treatment for those in need of treatment and to minimize the risks to me and to the society in which we live.

I have read and I understand the document above and acknowledge so by initialing each statement and signing below. I have been offered a copy of this document for my records.

Patient _____ Date_____ Witness_____Date_____