#
Name:
DOB:
Chart:
Age/Gender:
Date:

Medication Contract

I understand that the medical treatment I receive may include opioid medicine, also known as narcotics, pain medicine, analgesics, and/or sedative medications. I understand and agree with the following:

1. Opioid and/or sedative therapy will not cure my underlying disease or condition.
2. The goals of these medications are to increase my activities at home and/or work and decrease my pain symptoms and behavior within the time specified in my treatment plan.
3. My chronic pain represents a complex problem that may benefit from physical therapy, surgery and behavioral medicine treatments. My active participation in the management of my pain is extremely important. I will actively participate in all pain management treatments prescribed by the providers at Suburban Orthopaedics.
4. Opioid, and/or sedative medications may be addictive, and abuse of these drugs may have harmful effects on my health. Common side effects that are related to opioid medication are: nausea and vomiting, drowsiness, itching, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction, constipation and the possibility that the medicine will not provide complete pain relief. It is my responsibility to notify my medical provider for any side effects that continue or are severe (i.e. sedation or confusion).
5. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might be slowed. Such activities include but are not limited to: operating heavy equipment or a motor vehicle, working while operating machinery or around dangerous equipment, or being responsible for another individual who is unable to care for him/herself.
6. <u>I will not obtain an opioid or sedation medications from any source other than the providers at Suburban Orthopaedics</u>. If I require emergency treatment, that requires opioid or sedative medications I will notify my provider Suburban Orthopaedics the next business day.
7. I will receive all medications from one pharmacy. If I change pharmacies I will immediately notify the providers and staff at Suburban Orthopaedics of that change. I will furnish the providers and staff at Suburban Orthopaedics with the name and phone number of this pharmacy for the purpose of random verification of prescriptions.
8. I authorize the providers and staff of Suburban Orthopaedics to communicate with and provide this contract to my pharmacy and my other physicians.
9. Lost or stolen medications and/or prescriptions will not be replaced. It is my responsibility to report lost or stolen medications to the police.
10. I understand the opioid medication is strictly for my own use. The medication should never be given to others.

(continued on next page)

11. All medications are to be taken strictly as prescribed for dosage and frequency. I understand that increasing my dose without close supervision of my physician could lead to drug overdose causing sever sedation, respiratory depression and death. Decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal. Withdrawal symptoms my include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, goose bumps, abdominal cramps and diarrhea. These symptoms can occur after the last dose and can last up to 3 weeks.
12. I will not use any illegal substances, including but not limited to marijuana, cocaine, etc.
13. I will notify my medical provider before taking Benzodiazepines (drugs like Valium or Ativan), sedatives (drugs like Soma, Xanax, Fiorinal) and antihistamines (drugs like Benadryl). I understand the combined use of the above drugs and opioid may produce profound sedation, respiratory depression, blood pressure drop, and death.
14. Urine drug screens may be performed by the providers at Suburban Orthopaedics to monitor drug usage.
15. Refill requests must allow 3 business/working days to fill the request. No requests will be filled on evenings, Fridays, Saturdays or Sundays UNDER ANY CIRCUMSTANCES.
16. Any specific medication warning must be followed, i.e. drowsiness.
17. Office visits as scheduled by the providers at Suburban Orthopaedics must be kept in order to continue receiving refills on your prescribed pain medication.

I understand that if I have a problem or question regarding any of the information provided in this agreement I must make an appointment to discuss this with a medical provider at Suburban Orthopaedics to clarify information BEFORE A PROBLEM OR CRISIS SITUATION ARISES.

In particular, if I have had a history of drug or alcohol abuse I must discuss this with a medical provider at Suburban Orthopaedics before being prescribed medication by said provider.

I understand that the providers at Suburban Orthopaedics will cancel my contract if I fail any part of the above agreement. Upon cancellation of my contract the providers at Suburban Orthopaedics will wither stop or taper me off my medications as necessary. A drug-dependence treatment program may be recommended.

I have read and understand this contract. A copy of this signed contract has been given to me for reference. All of my questions have been answered in a satisfactory manner. I understand my compliance with this contract is mandatory to continuing my medication treatment with the providers at Suburban Orthopaedics. I consent to the use of medication in the treatment of my pain as outlined in this contract.

Patient signature: ______________________________________ Date: _______________