This will confirm that you, , have been **diagnosed** with the following condition(s) causing you chronic intractable pain which effects your daily functions and goals:

The medication we are prescribing to treat this condition is:

In addition to a moderate (~1/3) **reduction in your pain**, the goal of treatment with these medications is to increase functionality and achieve goals to improve your quality of life.

We agree that the following **additional ways** of managing your pain and reaching your goals include:

**Notice of Risk: The use of controlled substances may be associated with certain risks such as, but not limited to:**

1. **Central Nervous System:** Sleepiness, decreased mental ability, and confusion. Avoid alcohol while taking these medications and use care when driving and operating machinery. Your ability to make decisions may be impaired.
2. **Cardiovascular:** Irregular heart rhythm from mild to severe.
3. **Respiratory:** Slowing of respiration and the possibility of inducing wheezing, causing difficulty in catching your breath or shortness of breath in susceptible individuals.
4. **Gastrointestinal:** Constipation is common and may be severe. Nausea and vomiting may occur as well.
5. **Dermatological:** Itching and rash.
6. **Endocrine:** Decreased testosterone (male) and other sex hormones (females); dysfunctional sexual activity.
7. **Urinary:** Urinary retention (difficulty urinating).
8. **Pregnancy:** Newborn may be dependent on opioids and suffer withdrawal symptoms after birth.
9. **Drug Interactions** with or altering the effect of other medications cannot be reliably predicted.
10. **Tolerance:** Increasing doses of drug may be needed over time to achieve the same pain relieving effect.
11. **Physical dependence and withdrawal:** Physical dependence develops within 3-4 weeks in most patients receiving daily doses of these drugs. If your medications are abruptly stopped, symptoms of withdrawal may occur. These include nausea, vomiting, sweating, generalized flu-like symptoms, abdominal cramps, abnormal heartbeats. All controlled substances need to be slowly tapered off under the direction of your physician.
12. **Addiction (Abuse):** This refers to abnormal behavior directed towards acquiring or using drugs in a non-medically supervised manner. Patients with a history of alcohol and/or drug abuse are at increased risk for developing addiction.
13. **Allergic reactions:** Are possible with any medication. This usually occurs early after initiation of the medication. Most side effects are transient and can be controlled by continued therapy or the use of other medications.
14. **Accidental Overdose:** In some instances, controlled substances may accumulate, leading to respiratory difficulty, coma, or death. This risk is increased by certain medical conditions, higher dose opioid treatment, other medications including tranquilizers, CNS depressants, alcohol, marijuana or other illicit drugs.

**This confirms that we discussed and you understand the above, I asked you if you wanted a more detailed explanation of the proposed treatment, the alternatives and the material risks, and you (initial one):**

|  |
| --- |
| Are satisfied with the explanation and desired no further information. |
| Requested and received, in sufficient detail, further explanation of treatment, alternatives, and material risks. |

**Although these medicines can be very effective, they are designated as controlled substances by the government because they carry risk. It is important to monitors these medicines closely. I will follow the agreements below for receiving this medication. I understand that these exist to ensure my safety and wellbeing.**

# I will be treated with dignity and respect by Clinic X Health Centers’ staff.

# I commit to treat Clinic X Health Centers’ staff with dignity and respect.

# I will not take a higher dose of any medicine that my provider prescribes for me and I will not make any changes to how I take these medicines without consulting my care team.

1. I am responsible for my medicines; I am the only person who is allowed to take this medicine. I understand that lost, stolen or damaged prescriptions and/or medicines **will not be replaced**. I will not give away, sell or trade my medicines.
2. I will have at least one appointment with the Behavioral Health Consultant within 3 months of signing this agreement to assist me in learning to manage my condition. If I fail to attend the Behavioral Health Consultant appointment(s), my provider may discontinue these medications.
3. I will tell my own provider at Clinic X Health Centers, and any specialists outside of Clinic X Health Centers, about all medicines that I am taking both prescription and/or over-the-counter.
4. Medicines will be refilled only on the schedule set by my provider (usually, every 28 days) and as my provider chooses. **No early refills will be given, nor will they be given after normal clinic hours, on holidays, or on weekends.** I understand that I may be required to have an appointment with the Behavioral Health Consultant before my provider will give me a refill.
5. I will request all refills through my own provider at Clinic X Health Centers, and when at all possible, use the same pharmacy. This may take up to 5 business days to respond to my refill request. I will not attempt to get these medicines from any provider or clinic outside of Clinic X Health Centers.
6. In a medical emergency, an emergency room provider may prescribe additional controlled substances for chronic pain. If I go to the emergency department, I will tell that provider I am on a controlled substance agreement for chronic pain.
7. I agree to keep regular, follow-up visits with my provider according to my plan of care. I understand that cancelling or not showing up for any appointments may result in my provider not prescribing these medicines for me.
8. I understand that a urine drug test and/or a pill count may be requested at any time by my provider and the results may be used to determine whether I may continue to get these medicines. If I refuse or cannot give a urine sample, my provider may discontinue these medicines. Any use of street drugs, marijuana or alcohol is dangerous to my health, and my medications may be discontinued for my safety.
9. **My provider may stop all of these medicines if I fail to follow any of these rules and my dose of medicine may, or may not be, lowered before stopping completely.** If my provider stops these medicines, I will not be able to receive medicines like those above from any primary care provider in Clinic X Health Centers.

By signing below, I agree that my provider has discussed with me the limitations, expected effects, possible side effects and treatment plan associated with these medicines. I have read and understand this agreement. I have had a chance to ask questions. Any questions I have asked have been answered by my provider.

**SIGNATURE (Patient, Guardian or Person Authorized to Sign for Patient) NAME Please Print Date**

**SIGNATURE (Provider) NAME Please Print Date**

NOTE: If other than Patient or Parent, PROOF OF LEGAL REPRESENTATION MUST BE PROVIDED in the form of a custody order, guardianship order or medical power of attorney.

|  |  |  |
| --- | --- | --- |
|  | Health Centers Division | Patient ID |
| **Controlled Substance Agreement** | Name |
|  | DOB |
| Scan under CONSENTS | MRN |

Revised 8.8.19