ADVANCED ORTHOPAEDICS & SPORTS MEDICINE

CONTROLLED SUBSTANCE MEDICATION AGREEMENT

As a patient, you have the right to be informed about your condition, recommended drug therapy, and potential risks and hazards of treatment. Physicians and healthcare providers are required to provide patients undergoing drug therapy with information about that treatment. We expect to be partners in creating the best treatment plan for your pain management. If you cannot agree with the following points, it will result in discontinuing the controlled substance.

By your signature below, you are consenting and agreeing to the following:

1. I understand that as a patient of the Advanced Orthopaedics Pain Management Department, I will be evaluated for pain and may receive treatment intended to manage my pain. I understand that part of the treatment I may receive may include potentially dangerous, and/or controlled drugs (medications), including opioid or narcotic drugs. I understand that opioid and narcotic drugs can be harmful if taken inappropriately or without medical supervision. I further understand that opioid and narcotic drugs may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects. I understand that alternative methods of treatment, the possible risks involved and the possibilities of complications have been explained to me (us) and that I have the right to consent to or refuse treatment.
2. I understand that my physician (health care providers in Advanced Orthopaedics) has or will explain his/her treatment recommendations to me and that the specific medications(s) or drug therapy that she recommends will be described and documented separately from this agreement.
3. I understand that the drug therapy my physician may prescribe may involve using a drug that has been approved for some purpose(s) but has not yet been tested by the Federal Food and Drug Administration specifically for safety or effectiveness related to my type of condition. Current medical literature shows that such “off label” use may be beneficial to some patients, and I understand that recommended dosages are often exceeded when treating chronic pain in order to balance the benefit and risk to the patient.
4. I understand that if I choose to be treated with opioid or narcotic drugs I will undergo medical tests and examinations before and during my treatment. I understand that if I choose to be treated with opioid or narcotic drugs, I may be asked to consent to random unannounced urine and/or blood screening to check for drugs; I understand that I may also be asked to consent to consult with, or referral to, an expert such as a psychiatrist, psychologist, or addictionologist or other professional who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy. I understand that refusal to participate in such random unannounced checks for drugs or refusal to consent to consultation or referral may lead to the termination of my treatment by Advanced Orthopaedics Pain Management Department. Additionally, I understand that if I am in possession of or test positive for unauthorized substances, this may also result in the termination of my treatment by Advanced Orthopaedics Pain Management.
5. I will not accept or seek controlled substance pain medication for any other physician or health care provider, including an Emergency Room, while my physician is prescribing pain medication. It is essential that only one physician monitor and evaluate your pain medication. I agree to inform any health care provider who may treat me for any other medical problem(s) that I am enrolled in a pain management program. I will disclose to my physician all medication(s) that I take at any time, regardless of who prescribes them e.g. different procedure/surgery done by another physician.
6. All medication(s) should be obtained at one pharmacy in order to provide consistency, where possible and reasonably practical. Should the need arise to change pharmacies; I agree to inform my physician immediately.
7. I will take my medication exactly as prescribed and I will not change the medication dosage and/or frequency without the approval of my Physician.
8. I agree not to share, give or sell these medications. I agree not to permit others, including my family and friends, to have inappropriate access to these medications. I agree to properly dispose any unused medication.
9. I will keep regular scheduled appointments as recommended by my physician or to timely contact to reschedule if I am unable to keep a scheduled appointment
10. There may be times when my medication will need a refill between visits. Refill(s), if any, will generally not be permitted before the scheduled refill date. I understand that early refill(s) may be allowed when I am traveling. In this instance, I will call AOSM staff 2 days before my medication runs out. Refill requests will only be taken on Monday-Thursdays from 8:00 AM to 5:00 PM.

My Physician or the Physician on call for the group will not refill any pain meds after hours or over the weekend. This is not considered an emergency and will not be treated as such.

11. I understand that the most common side effects that could occur in the use of opioid and narcotic drugs used in my treatment include but are not limited to the following: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension (low blood pressure), arrhythmias (irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence on or addiction to the drugs, and death.
12. I understand that it may be dangerous for me to operate an automobile or other machinery while using opioid or narcotic drugs and that I may be impaired during all activities, including work.
13. The controlled substance medication prescribed is being given in order to control pain and allow me to function better. If there are any changes to my activity level or physical condition the treatment may be changed or discontinued. I understand that I may withdraw from this treatment plan and discontinue the use of the medications at any time; if I do so, I agree to inform my physician immediately. I further understand that I may be offered medical supervision when discontinuing medication use.
14. I understand that no warranty or guarantee has been made to me as to the resale of any drug therapy or the cure of any condition. I also understand that the long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which such medications provide long-term benefit.
15. If my medication(s) or prescriptions are lost or stolen, my physician may decide on a case-by-case basis, not to replace the medication(s) or prescription(s).
16. I recognize that chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, and certain other interventions. I agree to actively participate in all aspects of the pain management program recommended by my physician to achieve increased function and improved quality of life or to discuss questions, concerns or barriers to my participation with my physician.
17. I agree that I will not use any other illegal and/or recreational drug while receiving care and pain medication from this practice. Use of illegal and/or recreational drugs, especially while taking pain medication is extremely dangerous and potentially lethal. I acknowledge that I am not undergoing treatment for substance dependence (addiction) or abuse at this time.
18. I acknowledge that I am not involved in the sale, illegal possession, misuse/diversion or transport of controlled substances (such as narcotics, sleeping pills, nerve pills or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.).
19. I understand that this patient care agreement does not change or impact my rights to consent to other care and treatment, or my rights to refuse to participate in care and treatment. I understand that I may, at any time, refuse care and treatment.
20. I understand that I will sign this agreement and it will be placed in my medical record.
21. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment, and the drug therapy, medical treatment or procedure to be used to treat my pain, as well as the risks and hazards of such treatment, therapy, or procedures.
22. I believe I have sufficient information to sign this agreement. I voluntarily request that Advanced Orthopaedics treat my pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for medications to treat my pain, including the use of controlled and/or dangerous medications.

For females only:

1. To the best of my knowledge, I am not pregnant.
2. I agree to use effective contraception during my course of treatment. I accept that it is my responsibility to inform the physician if I become pregnant. If I am pregnant, or am uncertain about whether I am pregnant, I will notify my physician immediately. I understand that opioid and narcotic drugs may pose a significant risk to an embryo/ fetus/ unborn child/baby and that if I decide to be treated with opioid drugs or narcotic drugs, I am fully responsible for any injury to my embryo/ fetus/ unborn child/ baby.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Pharmacy Name: _____ Pharmacy Telephone Number : _____