

Tequesta Family Practice

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CONTRACT FOR USE OF CONTROLLED MEDICATIONS

Name: Testyapatient Testyapatient

Chart# 000000

Because of problems with chronic pain, it has been recommended that Testyapatient Testyapatient take the following medication on a regular basis:

By signing this contract, the patient, Testyapatient Testyapatient recognizes the following:

I have agreed to use medications prescribed by the physicians at The Pain Center as part of my treatment for chronic pain. These medications include but are not limited to opioids (morphine-like drugs), antidepressants, anti-seizure medications and muscle relaxers. These drugs are very useful but some of them have a potential for misuse and are therefore closely controlled by the local, state and federal government. Because my physician may prescribe such medication to help manage my pain, I agree to the following conditions. I am aware that failure to abide by ANY of these conditions will be considered a breach of the agreement, and at the sole discretion of my physician, may result in the termination of our physician-patient relationship.

1. I am responsible for my pain medications. I agree to take the medication only as prescribed and to contact my pain clinic physician before making any changes.
 - I understand that increasing my dose without the close supervision of my physician could lead to a drug overdose, causing severe sedation, respiratory depression and death.
 - I understand that rapidly decreasing or stopping any of my medications without the close supervision of my physician could lead to withdrawal or other adverse consequences such as seizures. Withdrawal symptoms from opioids may include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh", abdominal cramps and diarrhea. These symptoms can occur 24 to 48 hours after the last dose and can last up to three weeks.
2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician at the Pain Center.
3. I understand the side effects that are related to opioid medications. Common side effects are nausea and vomiting (similar to motion sickness), drowsiness and constipation. Less common side effects are mental slowing, flushing, sweating, itching, urinary difficulty and jerkiness. These side effects would occur at the beginning of my treatment and often go away within a few days without treatment. It is my responsibility to notify my physician of any side effects that continue or are severe (such as sedation or confusion). I am also responsible for notifying my pain physician immediately if I need to visit another physician or emergency room due to pain or if I become pregnant.
4. I understand that the medication(s) prescribed is/are strictly for my own use. The medication(s) should never be given to others. If children are 'in the house, a child-proof top is necessary.
5. I understand I must contact my pain physician before taking Benzodiazepines (drugs like Valium or Ativan), sedatives (drugs like Soma, Xanax or Fiorinal) and antihistamines (drugs like Benadryl). I understand that the combination use of the above drugs and opioids, as well as alcohol and opioids, may produce profound sedation, respiratory depression, blood pressure drop and even death. I will not consume alcohol nor will I use "recreational" drugs or illegal drugs while taking opioids, benzodiazepines or other sedating medications. If consumed, the consequence will be termination from the program. I understand that opioid prescriptions will not be mailed. During the time that my dose is being adjusted, I will be expected to return to the clinic no less frequently than one time a month. After I have been placed on a stable dose, I will return to the clinic whenever instructed by my physician.
6. I am responsible for my opioid prescriptions. I understand that refill prescriptions:
 - can only be written for a one-month supply and will be filled at the same pharmacy.

- shall be made during regular office hours, Monday through Friday, and can be picked up only in person. Refills will not be made at night, on holidays, or on weekends.
- shall not be made if I "run out early" or "lose a prescription" or spill or misplace my medication. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. Replacement prescriptions will be given at the discretion of my physician.

- shall not be made as an "emergency" such as on Friday afternoon because I suddenly realize I will "run out tomorrow". I will call at least 24 hours ahead to schedule pick-up for my prescriptions.

7. While physical dependence is to be expected after long-term use of opioids, signs of addiction (and psychological dependence) shall be interpreted as a need for weaning and detoxification.

- Physical dependence is common to many drugs, such as blood pressure medications, anti-seizure medications, antidepressants and opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal.

- Addiction is a psychological and behavioral syndrome that is recognized when the patient abuses the drug to obtain mental numbness or euphoria, when the patient shows a drug craving behavior or "doctor shopping," when the drug is quickly escalated without correlation to pain relief and/or when the patient shows a manipulative attitude toward the physician in order to obtain the drug. If the patient exhibits such behavior, the drug will be tapered. Such a patient is not a candidate for the opioid trial and he or she may be discharged.

- Tolerance is a pharmacological property of certain drugs and is defined as a need for higher doses to maintain the same drug-related effect.

8. I understand that the goals of my pain physician's treatment plan may include time-contingent use of opioids. If it appears to the physician that there is no improvement to my daily function or quality of life from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed by the physician.

9. I agree to submit to urine and blood screens at any time as determined by my physician to detect the use of both prescribed and non-prescribed medication. This will happen after any missed/rescheduled appointments

10. I authorize my medical providers to cooperate fully and completely with law enforcement agencies in investigation of any possible misuse, sale, or other diversion of my medication, I waive all privileges or right of privacy or confidentiality as it applies to any suspected drug diversion investigation by law enforcement agencies.

11. I authorize the release of any information and hospital records by the pain physician or his or her designee to other healthcare providers, my family, my employer, my insurance company or other reimbursing agencies.

12. I further understand that if I do not follow any of the above conditions or provision, I may (at my physician's discretion) no longer receive any type of opioid or other controlled medication. I also understand that if I have a problem or question with any of the above paragraphs, I must make an appointment to discuss this with the pain physician and receive clarification before a problem or crisis situation arises.

13. I understand that missed appointments will be grounds to be discharged from the practice and/or not given further controlled substances.

I have read the above information (or it has been read to me), have received a copy of the contract and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in opioid medication therapy.

Patient signature _____

Patient- Testyapatient Testyapatient DATE: 01/16/2011

Pharmacy name: _____

Pharmacy phone: _____

R. J. Oenbrink

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