

Internal Medicine & Family Practice, S.C.  
1719 Glenwood Avenue  
Joliet, IL 60435  
NARCOTIC AGREEMENT

Patient Name: \_\_\_\_\_

Physician Name: \_\_\_\_\_

The purpose of this agreement is to protect patient access to controlled substances due to chronic pain and our ability to prescribe medication to the patients.

Long-term use of controlled substances is controversial because of the uncertainty regarding the extent of long-term benefit versus the risk of developing an addictive disorder or relapses into prior addiction. String accountability is necessary due to the potential for abuse or diversion of therapeutic regimen. Therefore, the following will be an agreement by you, the patient, as consideration for, and a condition of, the willingness of the prescribing practitioner whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. All controlled substances must come from the prescribing practitioner whose signature appears on the prescription. During his/her absence, a designated practitioner may have authorization for an exception. (Caution: Multiple sources can lead to adverse drug interactions or poor coordination of treatment.)
2. The controlled substances must be obtained at the same pharmacy. If the pharmacy is changed, the office needs to be notified. The Pharmacy selected is: \_\_\_\_\_ in the city of: \_\_\_\_\_ Pharmacy Telephone: \_\_\_\_\_.
3. You are expected to inform the office of any/all new medications, new medical conditions, and/or adverse reactions to current medications.
4. Prescribing practitioner has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other health care professionals to maintain continuity of care and accountability.
5. You are not allowed to dispense, sell, or overuse the medication dispensed.
6. Abrupt discontinuation of medication may cause withdrawal syndrome.
7. Unannounced toxicology screens may be requested and your cooperation is required. Presence of unauthorized/illegal substances will result in immediate dismissal from this practice.
8. Medications need to be kept in the original containers and safely stored away to prevent accidental or intentional ingestion by children or unauthorized persons. If medications are stolen, you must provide an official police report and a refill may be considered.
9. Medications will generally not be refilled early if the medication has been destroyed or misplaced. If refills are issued early the pharmacy will fill them on the appropriate date.
10. Monthly appointments are required for refills and management of your current chronic medical conditions.

I, \_\_\_\_\_ authorize Dr. *Masood/Hussain/McTabi/Hahn* to manage current medical conditions, consult necessary specialists, and prescribe controlled substances. If an ER visits are required, I authorize the above practitioner to discuss my current medical conditions and treatments with the ER practitioners.

I authorize Dr. *Masood/Hussain/McTabi/Hahn* to review my prescription use through the M.A.P.S. program, which is a government tracking system for controlled substances to ensure appropriate use of medication per the above agreement. If there is noted misuse the agreement will be terminated via certified mail.

I, the patient, have a responsibility to myself and all others around me to utilize my medication appropriately by not becoming involved in activities which may endanger life or result in lethal consequences to include, but not limited to, using heavy equipment or any motorized vehicle, working in unprotected heights, or being responsible for individuals who are unable to care for themselves.

I understand that this contract may be terminated at any time at the discretion of the above physician.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date