

Michigan Advanced Pain & Spine
27101 Schoenherr Road, Suite 200, Warren MI 48088
Phone: (586) 806-6466 Fax: (586) 806-6395

NARCOTIC MEDICATION AGREEMENT

You have agreed to receive narcotics for the treatment of your pain. It is important that you have an understanding of the risks and responsibilities that go along with this treatment. Please read each statement and sign this agreement/contract below. If you have any questions regarding this information or the office policy regarding the prescribing of narcotics, please request clarification.

I, _____, understand that:
Any medical treatment is initially a trial, and that continued prescription is based on evidence of benefit. I understand that the goal of using narcotics is to decrease my pain and increase my functional level. If my pain does not significantly decrease and/or my function increase, the medication will be stopped. I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, lightheadedness, dizziness, confusion, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, kidney or liver disease, sexual dysfunction, physical dependence, tolerance to analgesia, addiction, withdrawal and the possibility that the medicine will not provide complete relief. The overuse of narcotic medication can result in serious health risks including respiratory depression or even death. This medication will be strictly monitored and all of my medications should be filled at the same pharmacy. (Should the need arise to change pharmacies our office must be informed). The pharmacy that I have selected is:

Pharmacy: _____
Phone: _____

I cannot receive this medication by phone. I will not call the office to have a prescription called in. I am responsible for making and keeping scheduled appointments. Early refill requests will not be honored. I will take the narcotic medication only as prescribed. Any changes must first be discussed and agreed upon with the Michigan Advanced Pain & Spine physician(s). Medications will not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If my medication has been stolen and I complete a police report regarding the theft, an exception may be made. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them. I agree that only my Michigan Advanced Pain & Spine physician(s) will prescribe my narcotic medication. I will not obtain or use narcotics or other controlled substances from a source other than Michigan Advanced Pain & Spine. I will instruct my other physicians to confer with the Michigan Advanced Pain & Spine physician(s) for any changes or need for additional narcotic medications. If it is brought to the attention of the clinic that other providers are prescribing medications for me, the Michigan Advanced Pain & Spine clinic reserves the right to discontinue prescribing medications and/or discharge me from the clinic.

I have been given a copy of the Michigan Advanced Pain & Spine – Long Term Opioid Analgesic Medication Information packet and understand that I may ask the physician and/or pharmacist questions about my medication and treatment. I will inform my Michigan Advanced Pain & Spine physician of any changes in my medical condition, any changes in any prescription and/or over the counter medication that I take and of any adverse affects that I may experience from any of the medications that I take. I agree to tell my Michigan Advanced Pain & Spine physician my complete and honest personal drug / medication usage and history. I will not use any illegal “street drugs” while receiving medications from Michigan Advanced Pain & Spine. I will communicate fully and honestly with my physician about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain. Routine blood work and random drug screens may be a part of my treatment plan. I agree to have them done on the day the physician requests it.

The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability. If the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to my records. It is a felony to obtain narcotic medications under false pretenses. This could include getting medication from more than one doctor, misrepresenting myself to obtain medications, using them in a manner other than prescribed or diverting the medications in any other way (selling). I know that narcotic medications will be stopped if any of the following occurs:

- I trade, sell, or misuse the medication
- The clinic finds that I have broken any part of this agreement
- I do not go for a blood or urine test when asked
- My blood or urine test shows the presence of medications that the staff are not aware of, the presence of illegal drugs, or does not show medications that I am receiving a prescription for
- I get narcotics from sources other than University Pain Clinic
- Any member of the professional staff of University Pain Clinic feels that it is in my best interests that narcotic treatment is stopped
- Any aggressive behavior toward physician or staff
- I consistently miss scheduled appointments

It is understood that failure to adhere to this agreement may result in cessation of therapy with controlled substance prescribing (no narcotic prescriptions will be written) by Michigan Advanced Pain & Spine physicians.

I have read the Narcotic Medication Agreement and without question understand all of this agreement. By signing this agreement I affirm that I have read, understand and accept all of the terms of this agreement.

Patient signature: _____ Date: _____

Clinic Witness: _____ Date: _____