CRANMORE HEALTH PARTNERS
Primary, Pain, and Urgent Care

Controlled Substance Agreement

Name: _____ Date of Birth: _____

Please initial all items:

_____ 1. The Pain Management Providers will provide treatment and medications related to pain. I should consult my primary care provider for other non-pain related medical issues. If medications for pain are prescribed by my PCP, dentist, ER doctor, or others, I will contact my provider for permission BEFORE I fill the prescription or consume the medication. If the medication is administered in a true emergency, I will notify my provider as soon as possible. If I fail to inform my provider, I may be discharged from the practice.

_____ 2. I understand that there are risks involved with narcotic pain relievers. The risks include but are not limited to: constipation, sedation, altered appetite, allergic reactions, problems with coordination, sexual dysfunction, lowered testosterone, personality changes, bowel obstruction, respiratory depression, and birth defects/infant withdrawal at birth. Chronic use of opioid analgesics often result in tolerance (requiring more medication) and habituation (physical dependence on the medication.) If my medication is stopped suddenly or the dose decreased rapidly, I may experience withdrawal. Use of this medication may also result in psychological addiction and hyperalgesia (increased pain perception.)

_____ 3. I understand that opioids are NOT recommended for use during pregnancy due to the potential for harm to the infant. Babies born to women taking opioids often suffer withdrawals after birth and require prolonged medical care in a specialized nursery unit. Providers urge all women of childbearing age who are taking opioids for pain and are not using a form of dependable birth control, to discuss with their OB/GYN or primary care provider what methods might be appropriate. I also recognize that my provider will make decisions regarding my care based on what is best for the fetus in the event that I become pregnant. This decision may include decreasing, discontinuing, or changing my opioids to a potentially less harmful medication. I understand there is some risk of miscarriage with all of these options.

_____ 4. I will take my medications only as my Pain Management Provider prescribes them and I understand my provider must preapprove any adjustments. I understand my provider may not prescribe additional pain medications should I run out ahead of schedule. The provider might, if needed, prescribe alternative medications to ease the effects of withdrawals. I understand not taking my prescriptions as prescribed could cause the Pain Management Provider to discharge me from the practice.

_____ 5. I understand that the Pain Management Providers will generally not be available to prescribe medication during evenings, weekends, or after 12 noon on Fridays. It is my responsibility to my provider at least 3 (three) business days in advance of running out of medications.

_____ 6. I understand that the Pain Management staff are not obligated to seek prior authorization (PA) of medication not covered by my insurance.

_____ 7. I understand that I must call at least 24 hours in advance to any appointment if I need to cancel.

_____ 8. I understand that I must provide viable contact numbers at all times or my provider may not prescribe medications.

_____ 9. I understand that my pain medications are generally not to be adjusted over the phone. I must make an appointment to be seen in person.

_____ 10. I understand that if I am having intolerable side effects to my pain medications that I must stop the medication and immediately contact my Pain Management Provider or staff if at all possible.

_____ 11. I understand that my pain is my own pain, not my family or spouse's. Therefore, I need to be the person to communicate with the Pain Management Provider or staff if at all possible.

_____ 12. I understand that rude and disrespectful treatment of any staff is not tolerated.

_____ 13. I will inform my Pain Management Provider of any changes in any other medications I am receiving, including holistic/herbals, from other physicians or practitioners.

_____ 14. I understand that combining illegal substances with prescribed medications increases my risk of breathing difficulties, heart disorders, and sudden death. If I do so, I may be discharged from the practice or be asked to seek treatment at a drug rehab facility.

_____ 15. If I feel tired or mentally foggy in response to medications, I will not drive, operate heavy equipment, or serve in any capacity that might endanger the public or myself. I understand that this is most likely to occur during dosage adjustments and when starting new medications.

_____ 16. I will submit a urine specimen for drug screening (narcotics, cannabis, cocaine, amphetamines, PCP, Alcohol, benzodiazepines, and others) upon my provider's request as often as directed. My Pain Management Provider may ask that a clinical staff member observe me providing the appropriate specimen. If my drug screen indicates presence of illegal or otherwise inappropriate substances, I may be discharged or required to seek treatment at a drug rehab facility.

_____ 17. I understand that I may be required at any time to bring in my medication(s) for my provider to inspect, count, or destroy. I may never dispose of my pain medications myself without a staff member as a witness.

_____ 18. I will allow my Pain Management Provider to communicate with other providers regarding my medical care, consistent with HIPPA guidelines.

_____ 19. I will not sell, share, or trade my medication with anyone.

_____ 20. I will safeguard my pain medication from loss, damage, or theft. My Pain Management Provider may not replace lost or stolen medication and may choose to discharge me from the practice. Damaged prescriptions may be replaced at the pain provider's discretion.

_____ 21. I will never alter a prescription in ANY way. I understand this is a felony, punishable by incarceration.

_____ 22. I authorize my Pain Management Provider and my pharmacy to cooperate fully with any city, state, or federal law enforcing agency, including New Hampshire's Board of Pharmacy and the DEA, in the investigation of any possible misuse, prescription forgery, sale, or any other diversion of my pain medication. I understand that illegal substance use may be reported to the proper authorities. I may lose my rights to privacy or confidentiality with respect to these authorizations.

_____ 23. I will allow my Pain Management Provider to receive information from any pharmacy I have used.

_____ 24. I will have all my medications filled only at the pharmacy I have listed below. I will inform my Pain Management Provider of any pharmacy changes.

_____ 25. Pain medications may be continued as long as:

A. There is acceptable improvement in/maintenance of level of pain and function
B. Pain Medications are used according to the prescription or provider order
C. There are no significant unmanageable side effects

_____ 26. For women: I will notify my provider immediately if I become pregnant. To the best of my knowledge, I am not currently pregnant at this time nor am I trying to become pregnant.

_____ 27. For intrathecal drug administration system patients: I understand the importance of keeping my scheduled pump refill appointments. I understand that in the event that my insurance policy will not pay for the medication, that I am responsible for paying for my pump medication at the time of refill. I understand that if my pump is not refilled when it is running empty, that I risk going through withdrawal and that I risk my health and life if that occurs. I understand the importance of notifying my provider if I hear my pump beeping because it is close to running empty. I accept the responsibility if I allow my pump to run empty.

_____ 28. I agree that I will never use my medication prescribed to me to intentionally cause harm to myself and to use all such medications only as directed by my provider.

_____ 29. I understand that if I fail to adhere, even once, to any of these contract terms that my Pain Management Provider may decide to discontinue certain treatment or discharge me from the practice altogether. If discharged, one month's supply of current pain medications and/or anti withdrawal medications may be prescribed to me. I may be given a list of other pain specialists to contact upon request. I understand that my provider is under no obligation whatsoever to treat me after 30 days from discharge, even if I cannot find another pain provider.

_____ 30. I will abstain from taking alcohol with prescribed medications while under this contract.

I have read, understand, and will comply with this agreement. I have been given the opportunity to have any questions addressed regarding the above.

Name: _____

Pharmacy: _____ Location: _____

Primary Care Provider: _____ Location:_____

Patient Signature: _____ Date: _____

Pain Management Provider Signature: _____ Date: _____