CONSULTING ORTHOPAEDIC ASSOCIATES, INC.

CONTROLLED SUBSTANCE MEDICATION AGREEMENT

Patient's Name: _____

I understand that Dr. _____ (hereinafter to referred to as "Physician") is prescribing a controlled substance medication for pain management. This Controlled Substance Medication Agreement ("Agreement") is a tool for communication allowing us to work together in good faith and for you to understand the importance of this medication. In prescribing a controlled substance medication, we must partner with our patients to create the best treatment plan for your improvement and management of pain. This requires cooperation, trust and mutual respect. If you cannot agree with the following terms, we will be unable to prescribe controlled pain medication and the failure to continue to follow all terms will result in discontinuing the pain medication and/or dismissal from our practice.

1. I will take the medication exactly as prescribed and I will not change the medication dosage and/or frequency without the approval of my Physician.

2. I will keep regularly scheduled appointments with my Physician. There may be times when your medication will need a refill between office visits. If that occurs, please call our staff at least 1 to 2 days before your medication runs out. Refill requests will only be taken on Monday – Thursday from 8 am to 4 pm. In other words, any request for controlled substance pain medications after 4 pm on Thursday will not be considered for refill until Monday morning at 8 am. Your physician or an on-call physician will not refill any pain medications after hours or on weekends. If you have uncontrolled pain during a weekend, medical care should be sought from an emergency room or immediate care center.

3. The controlled substance pain medication prescribed is being given in order to control pain and improve function. If there are any changes to your activity level or physical condition, the treatment may be changed or discontinued. You are responsible for notifying your Physician of such changes.

4. I will be ready to taper or discontinue the controlled substance pain medication as my condition improves. If your condition does not improve your Physician may recommend additional conservative or invasive orthopedic procedures. **If your level of pain still does not allow you to taper and discontinue the controlled substance pain medication, you will be referred to a pain management specialist for management of your pain medications.**

5. I agree to act responsibly, including protecting and limiting access to these medications, and to dispose of any unused medication in a proper manner.

6. **You are not to accept or seek controlled substance pain medication from any other physician or health care provider outside of our practice while we are prescribing pain medication, including your primary care physician.** It is essential that only one physician monitor and evaluate your use of pain medication.

7. If you have another condition that requires the prescription of a controlled substance pain medication (narcotics, tranquilizers, barbiturates, or stimulants), you will be asked to coordinate all medications with that prescribing physician, including any pain medication for your orthopedic condition.

8. It is required that you use a single pharmacy for all prescriptions. You may use a chain of pharmacies with different branches, as the prescription information is available at all branches. This is required to make certain that your medications are known by a pharmacist able to evaluate any concerns about interaction of medications.

9. I understand that lost, stolen or misplaced prescriptions or pills will not be replaced. All patients are required to act responsibly with their medications. This medication is prescribed for you and only your specific pain needs. To allow others to use your pain medication is illegal and dangerous. This type of behavior will not be tolerated by your Physician or our practice.

10. 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 also taking pain medication, is extremely dangerous and potentially lethal.**

Patient Signature: _____

Date: _____