SPECIALTY PAIN MANAGEMENT CENTER

AJAY M. NARWANI M.D., PLLC

DIPLOMATE IN ANESTHESIA, AMERICAN BOARD OF ANESTHESIOLOGY
DIPLOMATE IN PAIN MEDICINE, AMERICAN BOARD OF ANESTHESIOLOGY

AGREEMENT FOR CHRONIC PAIN MEDICATION ADMINISTRATION

PLEASE READ AND **INITIAL** ALL SECTIONS BELOW:

_____I UNDERSTAND THE PURPOSE OF THIS AGREEMENT IS TO PREVENT MISUNDERSTANDINGS ABOUT CERTAIN MEDICATIONS THAT I WILL BE TAKING FOR PAIN MANAGEMENT. THIS IS TO HELP ME AND MY DOCTOR COMPLY WITH THE LAW REGARDING CONTROLLED MEDICATIONS.

_____I UNDERSTAND THAT IF I BREAK THIS AGREEMENT, SPECIALTY PAIN MANAGEMENT WILL STOP PRESCRIBING MY PAIN MEDICATIONS.

_____I AGREE THAT I WILL NOT MIX ALCOHOL WITH PAIN MEDICATION.

_____I AGREE THAT DRIVING OR OPERATING ANY TYPE OF MACHINERY WILL NOT BE ALLOWED WHILE I AM BEING PRESCRIBED OPIOID MEDICATION AS THIS COULD BE CONSIDERED "DRIVING UNDER THE INFLUENCE" BY LAW.

_____I AGREE THAT I WILL NOT USE ANY ILLEGAL SUBSTANCES, INCLUDING MARIJUANA.

_____I WILL NOT INCREASE OR DECREASE THE DOSAGE OF MY MEDICATION WITHOUT THE CONSENT OF THE PRESCRIBING PHYSICIAN. IF I FEEL THAT ADJUSTMENTS IN THE MEDICATION DOSAGE IS REQUIRED, I AGREE TO CONTACT THE PRESCRIBING PROVIDER AT SPECIALTY PAIN MANAGEMENT FOR AN APPOINTMENT.

_____I WILL NOT SHARE MY MEDICATIONS WITH ANYONE, NOR WILL I TAKE ANOTHER PERSON'S MEDICATION.

_____I WILL NOT SELL MY PRESCRIBED MEDICATIONS, EITHER TO PATIENTS OF SPECIALTY PAIN MANAGEMENT OR TO OTHERS.

_____I WILL NOT RECEIVE ANY PAIN MEDICATIONS FROM ANY OTHER DOCTORS. IF I AM GIVEN A PRESCRIPTION FOR A CONTROLLED SUBSTANCE, I AGREE NOT TO FILL THE PRESCRIPTION UNTIL I HAVE CONTACTED THE OFFICE AND HAVE DISCUSSED IT WITH A PROVIDER AT SPECIALTY PAIN MANAGEMENT.

_____I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO SAFEGUARD MY PRESCRIPTION **AND** MEDICATIONS. SHOULD MY PRESCRIPTION OR MEDICATION BE LOST, STOLEN, OR DESTROYED, UNDER NO CIRCUMSTANCES WILL IT BE REPLACED.

_____I WILL NOT CONTACT THE OFFICE TO SCHEDULE FOR AN EARLIER APPOINTMENT IF I HAVE OVER-TAKEN MY MEDICATION.

_____I UNDERSTAND THAT THERE MAY BE RISKS ASSOCIATED WITH THE USE OF PAIN MEDICATION, INCLUDING RISK OF DEATH, RESPIRATORY DEPRESSION, BOWEL AND BLADDER DYSFUNCTION, SEXUAL DYSFUNCTION, CHANGE OF APPETITE WITH POSSIBLE WEIGHT GAIN OR LOSS, CHANGE OF COORDINATION (WHICH MAY INTERFERE WITH DRIVING, OPERATING MACHINERY AND FINE MOTOR MOVEMENT) AND OTHERS.

_____I UNDERSTAND THAT THE CONTINUOUS USE OF PAIN MEDICATION MAY RESULT IN DEPENDENCE, ADDICTION, CHANGE IN PERSONALITY, AND SLEEP CHANGES.

_____I WILL REPORT ANY CHANGES IN MY MENTAL STATE, AS WELL AS POSSIBLE SIDE EFFECTS FROM MY MEDICATION.

_____I AGREE TO SUBMIT TO RANDOM URINE DRUG TESTING AND/OR PILL COUNT AT THE REQUEST OR NEED OF THE PROVIDERS ON AN AS NEEDED BASIS TO MONITOR MEDICATION COMPLIANCE WITH RECOMMENDED TREATMENT.

_____I UNDERSTAND THAT SUDDEN STOPPING OF PAIN MEDICATION CAN LEAD TO REBOUND PAIN, WITHDRAWAL SYMPTOMS, SEIZURES AND OTHER SYMPTOMS. I HAVE BEEN INFORMED NOT TO STOP ANY PAIN MEDICATION SUDDENLY UNLESS DECIDED JOINTLY BY MYSELF AND MY PAIN PROVIDER.

_____I AGREE TO ALLOW MY PAIN PROVIDER TO REVIEW ANY OF MY PAST MEDICAL OR PSYCHOLOGICAL RECORDS.

_____I AGREE THAT WHEN I HAVE ANY CONTACT WITH DR. NARWANI OR ANY STAFF MEMBER, I WILL NOT BE RUDE, AGGRESSIVE, SWEAR AND/OR BE DISRUPTIVE WITH ANY MEMBER OF THE OFFICE.

_____I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. I AGREE AND UNDERSTAND THAT NON-COMPLIANCE WITH THE ABOVE WILL RESULT IN FORMAL DISCHARGE WITH NOTIFICATION TO MY PRIMARY CARE PHYSICIAN AND OTHER TREATING PHYSICIANS.

Patient Name: _____ **DOB:** _____

Signature: _____ **DATE:** _____

Provider Signature: _____ **Witness Signature:** _____

PHARMACY NAME_____ **PHONE:** _____

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