



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 I will not use any illegal substances, including marijuana.

_____ 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 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 or sell my medications with anyone, nor will I take another person's medication.

_____ 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 understand and agree that I will not receive anti-anxiety medications known as benzodiazepines, or Soma, unless decided jointly by myself and my pain provider.

_____ I agree to submit to random urine drug testing and/or pill counts 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 or other patients.

_____ 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: _____