EXODUS PAIN CLINIC
INTERVENTIONAL SPINE & PAIN MEDICINE

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# LONG TERM CONTROLLED SUBSTANCE/NARCOTIC AGREEMENT

_____ Initial - If this line is initialed, I do not want controlled prescriptions. However, if I ever get controlled substances, I will need to sign this agreement in full.

**I understand and accept the following:**

_____ Initial – Early refills will not be given.

_____ Initial – I can not call after regular hours or weekends for prescription refills.

_____ Initial – All controlled substances must be obtained from the same pharmacy where possible. Should the need arise to change pharmacies (due to relocation or emergency), it is my/ patient responsibility to notify the Exodus Pain Clinic.

My preferred pharmacy is: _____

Name Cross Streets Phone

_____ Initial – I am expected to inform the Exodus Pain Clinic of any new medications, medical conditions, and any adverse effects I experience from any medications. I consent to have my electronic RX history from all physicians reviewed.

_____ Initial – I understand that medication should not be stopped abruptly, as withdrawal symptoms will likely develop.

_____ Initial – **Prescriptions and/or medications WILL NOT be replaced if they are lost, stolen, get wet, are destroyed, etc. UNDER NO CIRCUMSTANCE WILL THEY BE REPLACED. Prescriptions and medications are patient's responsibility to manage and secure.**

_____ Initial – **It is not advisable and it is illegal in the State of Idaho to drive while taking narcotics.**

_____ Initial – I WILL NOT request or accept pain medication from any other physician or individual while receiving medication from Exodus Pain Clinic. I understand by doing so I could be endangering my health and it is illegal. Exceptions will be made ONLY IF I have discussed this with Dr. Marsh, MD or while I am admitted to the hospital.

_____ Initial – Use of prohibited substances can interfere with my/patient opioid therapy and cause adverse effects. Therefore, I agree to notify my provider of the use of all substances, to

include, marijuana, alcohol, and illicit drugs. I understand that I should not be using these substances while on opioid therapy.

_____ Initial – Medication changes will NOT be made over the phone. A "doctor visit" is required to re-evaluate medications.

I WILL NOT DESTROY ANY OF MY UNUSED MEDICATION. I WILL BRING IN ALL MEDICATIONS IN THEIR ORIGINAL CONTAINERS TO GET A NEW PRESCRIPTION IF MY CURRENT ONE IS NOT EFFECTIVE FOR MY TREATMENT.

_____ Initial – I will take the medication at the dose and frequency prescribed by my provider. I UNDERSTAND THAT I AM NOT TO INCREASE THE DOSE OF MY MEDICATION. By doing so I may no longer receive controlled substances from Exodus Pain Clinic providers.

_____ Initial – **Prescriptions may take up to 48 hours to refill. I will be responsible and plan accordingly in order to get my refills on time and will also plan for weekends/holidays so I will not run out of my medication. <u>Same day requests or walk-in requests WILL NOT be honored or filled.</u>**

_____ Initial – Opioids have common potential side effects that include: constipation, sweating, itching/rash, and allergic reactions. Drowsiness may occur when starting or increasing dosage. I will refrain from driving motor vehicles or operating machinery until drowsiness subsides.

_____ Initial – I will be randomly drug tested by my physician/provider to monitor my compliance with proper medication use. I waive certain privacy rights so that my physician/provider may talk to other healthcare providers, family members, and even law enforcement officials. I also agree to come into the office when asked and submit to a drug screen or produce unused portions of medications to verify they are being taken correctly.

_____ Initial – I can become dependent on opioid medications which in a small number can lead to addiction. If addiction occurs my physician/provider will discontinue the medication and I will be referred to a drug treatment program.

_____ Initial – I fully understand that if I violate any of the above conditions that my controlled substance prescriptions and/or treatment with Exodus Pain Clinic may be immediately terminated and I risk being discharged from the clinic. I also understand that this may result in withdrawal symptoms.

***Wait to sign in front of Exodus Pain Clinic Staff***

Patient Name (print): _____ Date: _____

Patient Signature:_____

Witness Initials: _____