INTERVENTIONAL PAIN INSTITUTE

CONTROLLED SUBSTANCE AGREEMENT

This agreement relates to my use of controlled substances for chronic pain prescribed by a physician at the Interventional Pain Institute. I have been informed and understand the policies regarding the use of controlled substances that are followed by the staff at the Interventional Pain Institute.

If the treating pain physician at the Interventional Pain Institute thinks you may be a candidate for opioids or other controlled substances, they may require a psychiatric evaluation and urine toxicology testing before deciding to prescribe. The treatment goal is not 100% pain relief. The treatment goal is a significant degree of pain relief that results in improvements in function. In the event that you cannot be stabilized on medications, then controlled substances may then be withdrawn.

I understand that I will be provided controlled substances while actively participating in this program only if I adhere to the following conditions:

1. I will use the prescribed medications only as directed by the Interventional Pain Institute physician.
2. I may not receive replacement medications for any medications which have been lost or have been stolen.
3. I will receive opioid pain medications only from the Interventional Pain Institute physician. Information that I have received opioid medication from any other sources may lead to discontinuation of treatment.
4. I will not expect to receive additional medication prior to the time of my next scheduled refill, even if my prescription runs out.
5. I will accept generic brands of my prescription medication.
6. If it appears to the physician that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will gradually taper my medication as directed by the prescribing physician.
7. I agree to submit to urine and blood screens to detect the use of the prescribed and non-prescribed medications (including “street” drugs) at any time.
8. I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy and behavioral medicine strategies. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the treating physician’s treatment plan to maximize functioning and improve coping with my condition.
9. I agree to schedule and keep follow-up appointments with my Interventional Pain Institute physician at recommended intervals. I understand that failure to keep appointments may lead to discontinuation of treatment.
10. I am responsible for keeping track of the amount of medication left and to plan ahead for arranging the refill of my prescriptions in a timely manner so I will not run out of medications. *
11. I agree to use one pharmacy for filling all my prescriptions except in case of emergency.
12. If I violate any of the above conditions, my obtaining prescriptions and/or treatment at the Interventional Pain Institute may be terminated.
13. If the violation involves obtaining controlled substances or any prescription for my pain condition from another individual or if I engage in any illegal activity such as altering a prescription, I understand that the incident may be reported by my Interventional Pain Institute physician to other physicians caring for me, local medical facilities, pharmacies and other authorities such a the local police department, Drug Enforcement Agency, etc. as deemed appropriate

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for the situation.

MEDICATION REFILL INFORMATION:

A. **Advance notice of 3 business days is required for refills of prescriptions.**
B. Requests for scheduled refills must be telephoned or faxed from your pharmacy. Refills **will not** be made at night, on holidays, or on weekends.
C. Most controlled substances cannot be telephoned in to a pharmacy. You must make arrangements to pick up your prescription during regular business hours or allow time for the U.S. Postal Service to get the prescription to your pharmacy.

THIS AGREEMENT WILL SUPERSEDE ALL OTHER AGREEMENTS.

BY SIGNING BELOW I INDICATE THAT I UNDERSTAND AND AGREE TO ALL THE TERMS OF THE ABOVE CONTRACT. I HAVE RECEIVED A COPY OF THIS FOR MY OWN RECORDS.

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Patient **Date**