

## **NARCOTIC CONTRACT**

The purpose of this contract is to maintain a safe, controlled treatment plan. I am asking for narcotic pain medication because other treatments and medications I have received have not given enough pain relief. It is unlikely that any medication will completely take away my pain, but for humane reasons, narcotic pain medication will be given to me as long as my pain continues, provided that I follow the terms of this contract.

I understand that the possible complications of chronic narcotic therapy include:

- chemical dependence (addiction)
- constipation, which could be severe enough to require medical treatment
- difficulty with urination
- drowsiness
- nausea
- itching
- slowed respiration
- reduced sexual function

If I take more medication than what is prescribed, a dangerous situation could result, such coma, organ damage, or even death. I understand that if I run out of my medication too soon, or if my medication is stopped suddenly, I could have narcotic withdrawal symptoms which can be very uncomfortable or dangerous. If I become pregnant, there are known or unknown risks to the unborn child which include narcotic addiction and the possibility of the baby experiencing narcotic withdrawal at birth. I am obligated to let my doctors know if I am pregnant, and they will help me find ways of controlling my pain without narcotics.

The terms of this contract include the following:

1. Only one pharmacy will be used for filling narcotic prescriptions,

The pharmacy you have selected is:

\_\_\_\_\_

Phone #: \_\_\_\_\_

2. If it is found that I received a prescription for narcotic medications from a source other than (doctor/clinic) I will be discharged from (doctor/clinic) and any prescriptions for narcotic medication will be discontinued.
3. It is necessary to call (doctor/clinic) Monday through Friday (9:00 a.m.-5:00 p.m.) to refill medications. It is important to make sure that I have enough medication to get through the weekend or after hours.
4. The physician on call or after hours and on weekends will NOT fill my medications. They do not have charts available for review to make decisions regarding medications.
5. I agree and will sign a release to allow (doctor/clinic) doctors to communicate with my referring physician, primary care physician and any pharmacists regarding my use of medications.

6. I will contact and communicate with (doctor/clinic) about narcotic and other pain-related medications and side effects. I will NOT contact physicians who do not work at (doctor/clinic) regarding the above concerns. If I have a significant side effect that occurs after hours or during the weekend, it is appropriate to go to the emergency room at the nearest hospital.
7. I agree to take the narcotic medication exactly as instructed by (doctor/clinic) doctors. I am NOT allowed to change dosage amounts or alter the time schedule of taking the medication without talking to a (doctor/clinic) staff member.
8. I agree that (doctor/clinic) will NOT replace any lost, stolen, or inaccessible narcotic medications or narcotic prescriptions for any reason.
9. I must keep all regular follow-up appointments as recommended by (doctor/clinic) doctors. Failure to comply may cause discontinuation of narcotic prescriptions and possible discharge from (doctor/clinic).
10. (doctor/clinic) will NOT accept telephone requests for narcotic prescriptions or refills from anyone other than me.
11. All narcotic prescriptions must be picked up by me. If I am too disabled or sick, an exception may be allowed at (doctor/clinic)'s discretion.
12. I understand that the benefits of narcotic medications will be evaluated regularly using the following criteria of pain relief:
  - a. -increase in general functions
  - b. -increase in life activities
  - c. -improvement in pain intensity levels
  - d. -absence of unacceptable side effects
  - e. -if appropriate, possible return to work and maintenance of a job
13. I agree to periodic urine screens for other medications and drugs if (doctor/clinic) physicians deem appropriate.
14. I have been given information about the use of narcotic medications and possible risks of side effects including development of tolerance, dependence, addiction, and withdrawal problems due to the medications, and I agree to undergo narcotic administration,
15. I agree to NOT hoard medication or alter the narcotic prescription. These behaviors and other unacceptable behaviors will result in the discontinuation of narcotic prescriptions and possible discharge from (doctor/clinic).
16. I agree to the following:
  - a. That I am NOT currently abusing illicit or prescription drugs and that I am not undergoing treatment for substance dependence or abuse.
  - b. That I have never been involved in the sale, illegal possession, or transport of any drugs.
  - c. *For women only:* That I am not pregnant and that I will inform the physician if I become pregnant.

This form has been fully explained to me, I have read it or have had it read to me, and I understand and agree to the terms of this contract. If any part of this contract as outlined above is broken, I understand that it will result in the immediate discharge from (doctor/clinic) and discontinuation of narcotic prescriptions.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Physician/Witness Signature

\_\_\_\_\_  
 Date