

Patient Name _____ Medical Record Number _____

Physician Name _____ Telephone Number _____

I agree to abide by the following guidelines for managing my prescription for opiate pain medications:

1. I will only request and receive opiate (narcotic) pain medications and any other controlled substances from Dr. _____ or from his/her designee in the Internal Medicine Clinic Pain Service. I agree to inform any other physicians participating in my care of this agreement. If another physician wishes to suggest changes in pain management, they can contact Dr. _____ during regular business hours, but no changes will be made without such contact.

2. Dr. _____ and I have agreed that I will receive the following:

medicine _____, directions _____ quantity _____, per ____ days,

medicine _____, directions _____ quantity _____, per ____ days,

The medical record will reflect any medication changes.

I will not request refills prior to this date. I understand that if my medicines are lost or stolen, they will not be refilled prior to the next refill date. If I use up my supply of medication before the date of the next refill, I understand that my doctor will not provide extra medication. I further understand that I may suffer symptoms of withdrawal. I will inform my doctor in a timely manner if I miss taking a dose of my medication, have an increased need for the pain medication, or have difficulty taking the medication as prescribed. If I find that the current dose of pain medication is no longer adequate, I will discuss this situation with my doctor at a scheduled visit.

3. I agree to use _____ Pharmacy, located at _____, telephone number _____, for filling prescriptions for all of my pain medicine.

4. I will bring all unused pain medicine to every office visit, including all current prescription vials.

5. While this contract is in effect, I will not abuse alcohol or use illicit drugs, including marijuana. As a part of this program, urine drug screening will occur at enrollment and at future visits.

6. I will not sell or share opiate medications, or other controlled substances.

7. If I violate the terms of this contract, I understand that my doctor and other doctors in the Internal Medicine Clinic will no longer prescribe opiate medications or other controlled substances for me. If this occurs, I understand that I may receive care elsewhere or continue with my current doctor and not receive opiate medicines. If I change doctors, I agree to allow my current physician to contact my new physician to transfer medical information including information about chronic pain treatment.

8. I understand that my doctor may verify whether or not I have a history of criminal drug convictions.

9. I understand that my doctor may use the North Carolina Controlled Substances Reporting System to verify that I am not receiving controlled substances from other providers.

Patient Signature _____

(print name) _____

Witness _____

Date _____