



RUSH PAIN CENTER

Informed Consent and Agreement for Controlled Substance Prescriptions

The Purpose of this consent is to establish an expected code of conduct and prevent misunderstanding about certain medicines you are taking, or may begin taking, for pain management. This is to help both you and your physicians to comply with the laws regarding controlled substance/pharmaceuticals. In addition, the following cautions should be understood:

- Overuse or over dosage of pain medication can result in lethal side effects, including decreased ability to breathe and death. Use of alcohol increases these risks.
- Opioids may impair one's ability to drive and operate heavy machinery.
- If pregnant, narcotics should be continued only with approval of the patient's obstetrician/gynecologist
- I understand that my continuation in treatment at the Pain Center is contingent on my compliance with the following terms and conditions and that I may be discharged from the Pain Clinic if I violate any of the following:

I acknowledge:

The goal of my treatment is to decrease my pain and improve my quality of life.

My medications(s) may be tapered and discontinued entirely if it is felt by my providers that I am not improving or fail to become more functional

I will bring all medication containers for prescriptions written by my pain management physician to each visit

If I lose my medication(s) or if they are stolen I may have to do without medicating(s) until my next regularly scheduled appointment.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well medication is helping to decrease the pain and increase my functionality and activities of daily living.

I will not use any illegal substances, including marijuana, cocaine, methamphetamine, ecstasy, etc.

I will not use any controlled medicine(s), including opioids (narcotics), sedatives, stimulants, or anti-anxiety medications from any other physician or source. The only exception being anti-anxiety medications prescribed by a licensed mental health care practitioner.

I will safeguard my pain medicine from loss, theft or use by others. Replacement of lost or stolen medicines will be considered only if I provide the doctor with a police report filed the day of the theft

If a change in medication is made, I will return any medications remaining from the prior prescription to the pharmacy from which they were obtained in order to receive the new prescription.

I agree that refill requests of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings, weekends, or holidays. No prescriptions will be mailed

I understand that if I break or do not comply with this Contract my doctor will stop prescribing these controlled substances/pharmaceuticals. In this case, my doctor may or may not taper off the medicine, to minimize withdrawal symptoms. In addition, treatment through a drug-dependence treatment program/specialist and/or the Pain Center psychologist may be recommended.

I authorize the Rush Pain Center doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine, I authorize the Rush Pain Center to provide a copy of this Contract to my pharmacy upon my request. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree to voluntarily submit to a blood or urine test when requested by my Rush Pain Center physician to determine my compliance with my program of pain control medication and to determine medication levels. A copy of this agreement will be provided to me. This testing will be done as described.

Patient's Signature/Date

Pain Center Staff Signature/Date

Witness/Date

Patients Printed Name/Date
