Boulder Community Health
Ambulatory Services Department ***Clinic Name*:**_____***Provider*:**_____

Provider-Patient Agreement for Long-term Controlled Medications

I understand that I have a chronic pain problem that currently requires the use of controlled medication to increase my function. The risks, side effects and benefits of the medication have been discussed with me in detail.

I, _____ understand that I must comply with and adhere to the following conditions in order to receive my controlled medications.

_____ I will obtain all my controlled substances from the physician whose signature appears below or, during his or her extended absence, by the covering physician_____

_____ I will obtain all my controlled medication from one pharmacy. Should the need arise to change pharmacies, our office must be informed. The pharmacy I select is: _____

_____ The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability. If responsible legal authorities have questions concerning your treatment, as might occur, for example, if you are obtaining medications from several pharmacies, we will provide full access to our records as required by law

_____ I agree to use my medication only as directed.

_____ I agree to periodic unannounced blood and/or urine tests to assess my compliance. Presence of unauthorized substances could prompt a referral for assessment of an addictive disorder.

_____ I will not increase, decrease or abruptly stop taking my medication without my provider's knowledge and permission.

_____ I understand I can only receive controlled medication refills at scheduled appointments. I agree to schedule an appointment no longer than every 60 days as directed by my provider for the purpose of renewing my prescriptions and assessing my progress.

_____ I understand I will not receive controlled medication refills over the phone or by mail. Early refills will generally not be given, though arrangements for travel can be made with my provider.

_____ Medications generally may not be replaced if lost, destroyed/damaged, or stolen. Stolen medications with a completed police report are an exception. My provider may consider replacing lost, misplaced or stolen controlled medications only at an appointment.

_____ I understand that it is my responsibility to schedule a more urgent appointment if I begin to experience any problems associated with my controlled medications or other medical conditions that may be affected by my medication arise.

 ***Clinic Name*:_____*Provider*:_____**

_____ I will not use alcohol, illegal, or narcotic drugs not prescribed by my provider with my controlled medications.

_____ I will not sell or share my controlled medications, allow others to use my medication, alter my medication prescriptions or use my medications in any unintended ways. I will keep my medications safely away from children.

_____ I will notify my provider if I intend on becoming pregnant or become pregnant.

_____ I understand that controlled medications can impair motor skills, therefore driving or operating heavy machinery while under the influence of a controlled medication is **not recommended**.

_____ Absolutely no use of alcohol or illegal substances will occur while driving.

_____ I understand that my provider may choose to discontinue my controlled medication if he/she believes that my pain is not improving, my medication usage is escalating, my functional ability is not increasing or if I begin to experience unacceptable side effects.

_____ I understand that failure to adhere to any of the conditions in this agreement, including drug screens that do not show the substances I am prescribed or show illegal substances, may result in the clinic declining to fill any further controlled substances as part of your care.

_____ I understand the eventual goal of tapering my controlled medications. In accordance with state regulations, if you are prescribed a controlled medication, your name is entered into a state database for tracking and monitoring usage. The medical provider reviews this database at each visit.

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Notice of Risk

The use of controlled substances may be associated with certain risk such as, but not limited to:

Central nervous system: sleepiness, decreased mental ability and confusion. Avoid alcohol while taking these medications and use care when driving and operating machinery. Your ability to make decisions may be impaired.

Respiratory: depression (slowing) of respiration and the possibility of inducing bronchospasm (wheezing) causing difficulty in catching your breath or shortness of breath in susceptible individuals.

Gastrointestinal: constipation is common and may be severe. Nausea and vomiting may occur as well.

Dermatological: itching and rash.

Urinary: urinary retention (difficulty urinating)

Pregnancy: newborn may be dependent on opioids and suffer withdrawal symptom after birth.

Drug Interactions with or altering the effect of other medications cannot be reliably predicted.

Physical dependence and withdrawal: physical dependence develops within three to four weeks in most patients receiving daily doses of these drugs. If your medications are abruptly stopped, symptoms of withdrawal may occur. These may include nausea, vomiting, sweating, generalized malaise (flu-like symptoms), abdominal cramps, palpitations (abnormal heartbeats). All controlled substances (narcotics) need to be slowly tapered off under the direction of your physician.

Addiction (abuse): This refers to abnormal behavior directed towards acquiring or using drugs in a non-medically supervised manner. Patients with a history of alcohol and/or drug abuse are at increased risk for developing addiction.

Allergic reactions are possible with any medication. This usually occurs early after initiation of the medication. Most side effects are transient and can be controlled by continued therapy or the use of other medications.

I understand the risks and benefits of taking this narcotic and agree to the terms above.

Failure to adhere to the above policies may result in cessation of your controlled substance prescribing by this provider or referral for further specialty assessment.

Patient Name:_____ DOB:_____

Patient Signature:_____ Date: _____

Provider Signature:_____ Date:_____