Southwest Family Physicians
YOUR FAMILY IS OUR FAMILY

11900 SW Greenburg Rd
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# Patient Informed Consent and Controlled Substances Agreement

Definitions of opioids, benzodiazepines, and other controlled substances

- **Opioids**—An opioid medication is a derivative of morphine or similar compound and thus has strong pain relieving properties
- **Benzodiazepine**—A benzodiazepine is a drug that is related to Valium. Their primary role is for the treatment of anxiety.
- **Other related drugs**—For the purposes of this agreement, "other related drugs" includes medications such as muscle relaxants, stimulants, and non-narcotic analgesics. These medications may cause sedation, altered mental status, occasionally dangerous withdrawal effects when stopped abruptly, and may have medication interactions similar to or different from opioids or benzodiazepines.
- **Controlled substance**—For the purpose of this agreement, a controlled substance will apply to opioids, benzodiazepines, or other related medications as described above

Risks of opioids, benzodiazepines, and other controlled substances

- Physical dependence—The abrupt discontinuation of controlled substances could lead to withdrawal symptoms such as abdominal cramping, diarrhea, anxiety, hypertensive crisis, cardiac arrest or other cardiac dysfunctions, seizures, and death.
- Psychological dependence or addiction—The use of these medications may lead to behavior focused on the obtaining and misuse of the controlled substance.
- Overdose—May lead to respiratory arrest and death.
- Altered mental status—These classes of medications may cause confusion, sedation, drowsiness, problems with coordination, and changes in thinking ability. This may make it unsafe for you to drive a motor vehicle, operate hazardous equipment and machinery, or perform dangerous activities. Other side effects may include but are not limited to the following: nausea, constipation, unsteadiness, decreased appetite, difficulty urinating, depression, and loss of sexual drive with testicular atrophy (in males).

Frequently asked questions

- **What happens if I am leaving town and will not be around to pick up my prescriptions on the appropriate day?**

  At the description of your prescriber, prescriptions may be provided on an early basis so that your medications will be interrupted. We ask that you give us advance warning whenever possible. You need to know that your refill date will not be changed for the following month and that you will be responsible to self-manage your pain and use appropriate amounts of medications so that you don't run out early the following month. You may want to get a medication box to help you track the amount of medication you are taking daily.

- **What happens if I am given a prescription for controlled substances by an emergency room doctor or my dentist?**

  If you are being prescribed controlled substances from this office you will be asked to sign a pain contract which prohibits you from seeking such medications from other prescribers. This agreement does not prohibit you from seeking care for acute issues from another provider such as a dentist, surgeon, or emergency room physician. If you receive a prescription for a controlled substance in an acute setting, we ask that you notify this office immediately and be prepared to provide documentation of your visit as requested. Failure to do this may result in the discontinuation of all controlled substances prescribed by our office.

- **Why does this clinic use urine drug screens and pill counts?**

  Since we frequently prescribe medications that are classified as controlled substances by the federal government (due to the nature of the side effects and abuse potential), we are very careful about monitoring compliance with medication use. This tool helps monitor prescription use and decreases potential for abuse.

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# Medication Agreement for Use of Controlled Substances

I, _____, have agreed to use opiates (morphine like drugs) and/or controlled substances as part of my treatment for chronic pain and/or medical condition. These medications may improve my symptom control and allow me to be more active, but may not eliminate my pain. I understand that these drugs are very useful but have the potential for misuse and are therefore closely controlled by the local, state, and federal government. Because my provider is prescribing this medication to help manage my pain, I agree to the following conditions. (INITIAL ALL)

_____ AS PRESCRIBED: I agree to take the medication only as prescribed. I understand that increasing my dose without close supervision could lead to drug overdose, causing severe sedation, respiratory depression, and death. I understand that decreasing or stopping my medication without the close supervision of my provider could lead to withdrawal.

_____ NO SHARING OR SELLING: I understand that this medication is strictly for my own use. It should never be given to others.

_____ ONE PROVIDER: I will not request or accept this medication or any other controlled substance from any other provider or individual while I am being treated at this clinic. This agreement does not prohibit you from seeking emergency treatment for an acute, emergent illness, surgery, or injury. We need you to notify our office within one business day when such treatment includes short-term pain medications.

_____ ONE MONTH'S SUPPLY: Prescriptions for 1 month's supply of this medication to be in person.

_____ PRESCRIPTIONS GIVEN DURING OFFICE HOURS ONLY: Prescription will be made during regular office hours, Monday-Friday, from 9:00am - 4:30pm. Refills will not be written at night, on holidays, or weekends.

_____ NO EARLY REFILLS: I am responsible for keeping track of my medications. Refills will not be made if I run out early or lose a prescription.

_____ SECURE PRESCRIPTION: I understand that opiates and other controlled substances can cause serious illness or death to a pet or a child and will make every effort to keep such medications in a locked or secure place.

_____ NO UNSANCTIONED DOSAGE INCREASES: You may not increase the dose of your medication without your provider's approval. You are to take this medication as directed by your provider. If you take more medication than advised, such behavior may result in discontinuation of these medications and added doses will not be provided to make up for any shortfall created.

_____ NO CHANGES TO DOSE OR TYPE OF MEDICATION OVER THE PHONE: Changes to medication type or dosage cannot be made over the phone. You must make an appointment with your provider to discuss this issue in person.

_____ REGULAR APPOINTMENTS: During the time that my dose is being adjusted, I will return to the clinic as instructed by my provider. After I have been placed on a stable dose, I will return to the clinic for a medical evaluation at least every 3-6 months.

_____ NO MORE THAN 3 NO SHOWS OR LATE CANCELLATIONS: Per standard clinic policy, if I am unable to keep my appointment, I will call the clinic at least 24 hours in advance of my appointment time. Otherwise this will be considered a no-show. More than 3 no shows within 12 months may result in tapering and discontinuation of your medication as well as discharge from the clinic.

_____ URINE/BLOOD SCREENS: I agree to abstain from all illegal and recreational drugs and will provide urine or blood samples at any time to monitor compliance.

_____ ALTERNATIVE/ADDITIONAL THERAPIES: I will participate in other treatments at the direction of my provider, including behavioral health and physical therapy, and will be agreeable to taper or discontinue the drug as other treatments become available or if current treatment is not working.

_____ ONE PHARMACY: My prescriptions will always be filled at the same pharmacy.

_____ DISCONTINUE IF UNABLE TO FOLLOW THESE RULES: I understand that if I do not follow all of the above conditions, I may be gradually taken off this medication. I may also be discharged from the clinic.

**Pharmacy:** _____ **Pharmacy phone:** _____

**Diagnosis/Condition being treated:** _____

**Current Medication (dose & frequency):** _____

***I have read the above information, or it has been read to me, and all of my questions regarding the treatment of pain with drugs have been answered to my satisfaction. We have discussed potential side effects and possible alternatives in as much detail as I wanted. I hereby give my consent to participate in this therapy and agree to all terms stated above.***

Patient Signature: _____ Today's date: _____

Provider Signature: _____ Today's date: _____