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CENTER FOR PHYSICAL MEDICINE AND REHABILITATION

PRESCRIPTION MEDICATION TREATMENT AND DRUG SCREENING AGREEMENT

Center for Physical Medicine & Rehabilitation wants to work with you toward a common treatment goal; to improve your ability to function and/or work while managing your pain. In consideration of that goal, you may be treated with potent medications, some of which are narcotics or tranquilizers. These medications are controlled substances and are monitored by local, state, and federal agencies. The medications can be very effective when taken as directed under medical supervision; however, they do have the potential for misuse and abuse. With that potential, we will request from you, random urine and/or blood drug screening.
I therefore agree to abide by the following conditions:

- I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor agrees to treat me based on this agreement.
- I agree that all medications for pain control will be requested of and prescribed by only my physician. I understand that certain medications interact with others. I agree to inform my physician of any medication that I am taking, including medication purchased over the counter, prescriptions from other physicians, and especially if I obtain a prescription for pain control or related to my pain condition from any other source for any reason, I will not attempt to obtain any controlled medicines, including opioid pain medications, controlled stimulants, or anti- anxiety medicines from any other doctor.
- I will submit to initial and random urine or blood tests if requested by my physician at the hospital laboratory.
- 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 the medicine is helping to relieve my pain.

- I will not use any illicit substances, including marijuana, cocaine, etc.
- I understand that my medications were prescribed to be used by myself only and agree not to share, sell, or give my medications to anyone else. This is illegal, as well as dangerous to the other person.
- I agree to use my prescriptions exactly as written, including the prescribed dose, time, interval or frequency, and route. If I take my medication more often and use up my medication sooner than prescribed, I understand they will not be refilled early.
- I understand that some patients may develop tolerance to the medication, which results in the need to increase the dose of the medication to achieve that same effect in terms of pain relief. I also understand that as a result of other treatment, therapy, or the natural course of my disease process, my pain may change. Therefore, my medication doses will have to be adjusted (increased or decreased) as deemed appropriate by my physician. I will not adjust the medications myself.
- I will safeguard my pain medications from loss or theft. Lost or stolen medicines will not be replaced.
- I understand that some of the medications prescribed for my pain are controlled substances and therefore have the potential of physical and psychological dependence. If this happens, I will follow my physician's guidance and participate in any treatment program prescribed which may include medical treatment, psychological counseling and detoxification.
- I understand that to stop taking the medication abruptly may be dangerous and lead to withdrawal symptoms. If medications need to be discontinued, I will do so gradually and only under medical supervision by my physician or by another health care professional that I may be referred to by my physician.
- I am responsible for keeping track of the amount of medication left and plan ahead for arranging the refill of my prescriptions. I agree that refills of my prescriptions for pain medication will be made only at the time of an office visit or during regular office hours. I understand that it may take up to 72 hours for the physician to review my medical record and make a recommendation for a prescription refill. No refills will be available during evenings, weekends, or holidays.
- I agree to use one pharmacy for filling all of my prescriptions. I understand that in an emergency I could use a different pharmacy. If I do change pharmacies for any reason, I will notify my physician.
- I agree not to use the Automatic Refill Programs offered by pharmacies

Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Phone: _____

I understand that if I break this agreement, my doctor may stop prescribing these pain control medicines and I could be discharge from care. In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. A drug-dependence treatment program may be recommended. I will be provided with a phone number to the St. John Providence Health Physician Referral Line (888) 757-5463. My doctor will continue to treat me for urgent medical conditions for 30 days while I locate another physician, but no medications will be prescribed.

I understand that if the violation involves obtaining controlled substances through any illegal activity such as altering a prescription or selling the medications, the incident may also be reported by my physician to other physicians treating me, local medical facilities, pharmacies, and other authorities such as the local police department, Drug Enforcement Agency, etc. as is appropriate for the situation.

I agree that these guidelines have been fully explained to me. All of my questions and concerns regarding treatment have been completely answered. A copy of this document will be given to me upon my request.

Print Patient Name	Patient Number
Patient Signature	Date and Time
Physician Signature	Date and Time