Advanced Pain & Spine Institute OF MONTANA

CONTROLLED SUBSTANCE INFORMED CONSENT

for Patient: _____ DOB: _____

The purpose of this consent is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers and barbiturate, sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason, the following policies are agreed to, by you, the patient, as consideration for and a condition of, the willingness of the provider whose signature appears below to consider the initial and/or continued prescription of controlled substance(s) to treat your chronic pain.

1) I will try **not** to obtain ***ANY*** controlled substances, including opioid pain medications or controlled stimulants from anyone other than the provider whose signature appears below, or, in the case of his absence, by the covering provider, unless specific authorization is obtained for an exception.

2) I understand that all prescriptions must be filled at the same pharmacy. In the case that a need should arise to change pharmacies, I will contact my prescribing provider immediately. My pharmacy of choice is: _____

3) I understand that I must be seen **every three months** by my prescribing provider in the pain clinic to review my treatment plan. At that time, I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life and how well the medications are helping to relieve the pain. I will express concerns of over-sedation, fatigue, nausea, vomiting, constipation, euphoria or dysphoria.

4) I understand that controlled substances should not be taken with alcohol. Should I consume alcohol while taking a controlled substance, I do so despite these risks.

5) I understand that I may be required to bring original containers of medication to each office visit.

6) I understand that as part of the Interdisciplinary Pain Management Program, I will be required to attend all components of the treatment plan, in order to receive the maximum opportunity for improvement.

7) I understand that I am expected to inform my medical provider of any new medications or medical conditions and of any adverse effects I experience from any of the medications I take.

8) I recognize that my medical provider has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other health care professionals to ensure my accountability.

9) I recognize that these medications may be sought by other individuals with chemical dependencies and should be closely safeguarded. I will not share, sell or otherwise permit others access to my prescriptions.

10) I recognize that my prescriptions may be hazardous or lethal to other individuals.

11) I understand that I must take my prescriptions **as directed** and that if I use the medication more frequently than prescribed, I will be without medication until the date that I am due for a new prescription.

12) I understand that I must not stop taking my medication abruptly as withdrawal symptoms may develop.

13) I understand that under **NO CIRCUMSTANCE** will early prescriptions be given. Medications will not be replaced if they are lost, stolen, get wet, are destroyed, flushed down the toilet, etc. If your medication is stolen and you complete a police report regarding the theft, an exception may be made.

14) I agree to call prescription requests in to the dedicated prescription line **4 business days** prior to running out for pick up in the office or **7 business days** for mailing. I know that no requests will be honored on weekends, holidays or after hours and I will take the necessary steps to work around these requirements. I understand that the prescription line is checked at least once per day.
(DEDICATED PRESCRIPTION LINE **(406)327-3929**).

15) I agree to comply with random urine, blood or breath testing to ensure proper use of my medication.

16) I understand that if I present to an emergency room for any reason, I must notify my provider by the end of the following business day so they may obtain records from the visit. If I feel the emergency is related to my chronic pain treatment, I will contact my provider (or the on-call provider, if after hours) before visiting the emergency room and before receiving any pain medications.

17) I authorize my provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my prescriptions. I agree to waive any applicable privilege or right to privacy or confidentiality with respect to these authorizations.

18) I agree to waive my right to privacy and authorize my provider to discuss my medical care and use/misuse of medications with any health care provider, local emergency rooms and emergent care centers, legal authorities, pharmacies or the DEA. Please initial here _____.

19) I understand that my provider may stop treating me as a patient, in his/her sole discretion. If I am discharged from the program for misuse of my opioid mediation, area emergency departments and emergent care centers will be notified. Moreover, my provider may refer me to a substance abuse specialist if they have concerns about my well-being. Please initial here _____.

20) I have received and have read the additional information supplied to me by my provider regarding possible side effects and problems associated with my pain management prescriptions.

21) I understand that if my medications are lost, stolen, damaged or mishandled in any way, my provider may do any of the following:

a) Provide me with a taper schedule and discontinue my treatment with this medication.
b) Write the prescription for one week at a time and require that I fill the prescription weekly for a minimum of four weeks.
c) Require me to comply with other regulatory actions in order to continue receiving the medication.

22) I have been informed that my provider cannot legally write opioid prescriptions for me if I am using illegal substances. If I am found to be using or am suspected of using illegal substances, I will be tapered from my opioid medications.

I have read the above and understand all that this agreement entails. I understand that a breach of any of the above criteria will result in the discontinuation of my prescriptions and possible discharge from the Pain Management Program.

_____ _____
Patient Signature Date

_____ _____
Provider Signature Date

_____ _____
Witness Signature Date