RETURN

PRIMARY CARE HOUSE CALLS
Controlled Substance Contract

1. This is an agreement between the patient/applicant and Primary Care House Calls concerning the use of opioid analgesics (narcotic pain medications) and/or other controlled substance medications. These may be used for treatment of pain relief. They are not guaranteed to eliminate all pain but are expected to reduce it enough that I may become more functional and improve my quality of life.
2. I understand that opioid analgesics and other controlled substances are strong medications for pain relief and I have been informed of the risks and possible side-effects involved.
3. I understand that opioid analgesics and other controlled substances may cause a physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (i.e., flu-like symptoms such as nausea, vomiting, diarrhea, aches, sweating and/or chills) that may occur within 24-48 hours of the last dose.
4. I understand that if I am pregnant or become pregnant while taking controlled substance medications, my child would be physically dependent on these medications, and withdrawal can be life threatening for a baby.
5. Overdose by misuse of these medications may cause death by causing me to stop breathing. This can be reversed by emergency medical personnel if they know I have taken controlled medications. It is suggested that I wear a medical alert necklace or bracelet that contains this information.
6. Controlled substance medications may cause drowsiness, sedation or dizziness. I understand that I must follow provider and pharmacy directives while taking these medications. Such as not operating a motor vehicle or operate machinery that could put my life or other's lives in jeopardy.
7. I understand it is my responsibility to inform my provider of all side effects I experience while taking prescribed medications.
8. I agree to take these medications as prescribed and not change the amount or frequency of the medications without first discussing it with my provider. Requesting controlled substance medications early, escalating doses without the permission of my provider or losing prescriptions may be signs of misuse of the medication and may be reason for the PA/NP to discontinue prescribing.
9. I agree that opioids and controlled substances are to be prescribed only by my provider. I further agree to fill these prescriptions at one pharmacy. I agree not to take any controlled substances otherwise obtained. I give my permission for my PA/NP to verify that I am not obtaining prescriptions from other providers, or filling prescriptions at other pharmacies.

RETURN

10. I agree to keep my medications in a safe and secure place. Lost, stolen or damaged medications may not be replaced. In the case of stolen medications, a police report is required to refill the medication. The provider has the discretion to re-order medications as they deem appropriate.
11. I agree not to sell, lend, or in any way to give my medications to any other person.
12. I agree not to drink alcohol or take mood altering substances while I am taking opioids or other controlled substances. I agree to submit a urine/blood/swab testing for alcohol/drugs at any time my provider requests.
13. I agree that I will attend all required follow up visits with the prescriber to monitor these medications. I further understand that failure to do so will result in a discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities recommended by my provider.
14. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication(s). People with a history of alcohol or drug abuse issues are more susceptible to addiction. If this occurs, the medication will be discontinued, and I will be referred to a drug treatment program.
15. I have read the have, provided opportunity to ask and have my questions answered, and understand this agreement. I know that the PA/NP may discontinue this form of treatment at any time they deem appropriate.

____

Printed Name of Patient

____   __________________________

Signature of Patient   Date

We work closely with the DEA Strike Force to prevent Prescription Drug Abuse.

Primary Care House Calls, 2744 Gulf Breeze Parkway, Gulf Breeze, FL 32563

Phone 850-934-5713   Fax 850-934-0379