LONG TERM PAIN MANAGEMENT CONTRACT
FAMILY PRACTICE ASSOCIATES OF HOPEWELL

The purpose of this contract is to review guidelines that will be used in the treatment of your chronic pain. This contract will help you and your physician comply with the law regarding narcotic pain medications.

I, _____, agree to the following by signing this contract.

1. I understand that this contract is essential to the trust necessary in a doctor-patient relationship, and that my physician will help me manage my pain in the best way possible.

2. I must visit the doctor who prescribes my medicine at least once every one to two months to refill the prescription. My use of pain medicine will be reviewed at least every six months. Visits will be scheduled – no walk ins.

3. I may obtain refills only at the office visits. NO refills will be given on the weekends or evenings unless otherwise ordered by physician.

4. I agree to safeguard my pain medication from loss or theft. Lost or stolen medicine or prescriptions will NOT be replaced.

5. I agree to keep a list of all narcotics that I am taking and will bring them to each office visit.

6. I agree that I will submit to blood and/or urine testing at the request of my doctor to make sure that I am taking the medicine properly.

7. I agree not to use any illegal substances, including, but not limited to, cocaine, heroin, and marijuana.

8. I will not share, sell or trade my medication.

9. I will not attempt to obtain any controlled substances, including narcotics, anti-anxiety medicines, or stimulants, from another doctor.

10. I agree to purchase prescriptions from only one pharmacy.

11. I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

12. I understand that people who take narcotics can develop psychological and/or physical dependence. Narcotics may inhibit my ability to drive or operate machinery and the use of alcohol, sleep aids or tranquilizers with my pain medication may cause harmful effects to my brain.

13. I understand that stopping narcotics after long use may cause withdrawal symptoms. Early symptoms include sweating, tearing of eyes, runny nose, restless sleep and enlarged pupils. After 24-72 hours, symptoms may include irritability, diarrhea, back pain, stomachache, nausea/vomiting, fever, rapid heart rate, leg cramps, weakness and sneezing. Death may occur. To prevent symptoms, the dose of my medication should be reduced by half on a weekly basis.

14. I understand that breaking; crushing or chewing my medication can cause severe side effects, including death.

15. I understand that failing to comply with this contract will result in discontinuation of medicine. If necessary, the medicine will be tapered to avoid withdrawal.

16. I also will not call for refills until the day my controlled substance is due to be refilled. It will not be given to me until the day that it is due if I call the office for a refill.

My reason for taking this medication is _____.

My treatment will be _____.

I agree to obtain my prescription from _____.

I have read this contract, and agree with its entire contents.

PATIENT SIGNATURE: _____ DATE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

WITNESSED BY: _____