Narcotic Agreement for Joseph A. Christiano, Jr. M.D. & Amy Miltenberger PA-C

Patient Responsibility:

I,_____as a patient of _____, have received a copy of this agreement and consent and I agree that:

1. I understand that opioids/narcotics are unlikely to eliminate all my pain. My expectations include improved comfort, increased activity tolerance, and improved sleep.

Managing the Medication:

2. I will receive opioid pain medications, sedative medication, and muscle relaxants *only one assigned doctor* or his/her designee. If I have a Pain Medicine Specialist or other treating pain physician, I will provide his/her name to this office. I agree to allow contact with my treating pain physician to coordinate pain medicine care and certify that I will receive pain medicine *from only one physician*. If I obtain medications from another physician not designated here, from an emergency room, or other provider, I will notify my doctor as soon as I am taking the medication.

Pain Physician Name & contact information:

3. I will have all medications prescribed by my doctor filled at one pharmacy (or pharmacy chain). If, for whatever reasons (e.g., medication not stocked by pharmacy, financial or insurance purposes), I have some or all prescriptions filled at a pharmacy other than the one I regularly use, I will advise my doctor's office.

4. I will follow my doctor's procedure for getting refills. I understand that my doctor *will not refill these medications* during evenings, weekends or holidays.

Initial: _____

5. I will manage my medications responsibly:

5.1. It is my responsibility to have an adequate supply of my prescriptions. I will verify the number of pills dispensed prior to leaving the pharmacy when I pick up my prescription.

5.2. I will place my medications in a safe area at home where they cannot be lost, destroyed, stolen or ingested by other adults, children, or pets.

5.3. I will take my medication exactly as prescribed and not in excess of my doctor's instruction. If my pain is not controlled, I agree to call my doctor prior to taking any extra medicine.

5.4. I understand that if my medications are lost or stolen, or if I run out early, it is my doctor's policy not to re-write prescriptions. *I will not receive a new prescription until the next regular refill date.* This may mean that I will experience physical withdrawal symptoms.

6. I agree to provide a written explanation for my medical record if I ask for early refills, if I loose prescriptions, if I have them stolen, or if I obtain medications from a source other than my doctor.

7. I will not take illegal drugs or any additional opioid pain medications not prescribed by this office or the agreed upon pain medicine provider in item 2.

SIDE EFFECTS AND RISKS:

8. I have read and understand the following about the side effects of opioid pain medications. They include:

Mental side effects such as mental slowness, impaired judgment, feeling drunk, dizziness, drowsiness, poor concentration, shakiness, poor coordination, and increased tiredness.

Other side effects including interactions with other drugs, nausea, itching, rash, flushing, sweating, poor sex drive, new or increased leg or foot swelling, difficulty urinating, constipation, increased joint pain, sweats, new headache, and skin irritation at the site of medication patches.

Tolerance to the medication and withdrawal symptoms if I stop the medicine suddenly.

Increased dental problems such as cavities and dry mouth

I understand that side effects may require my doctor to stop or switch medications.

9. I have read and understand the following about mental effects of opioids**:**

Alcohol, sleeping aids, sedatives, some antianxiety medications, antidepressants, antihistamines, anti-seizure medicines, and muscle relaxants are some of the medicines that can increase the mental side effects of opioids. I must be extra vigilant for mental impairment if I take these substances along with opioids. I will ask my doctor if I am unsure whether it is safe to combine opioids with any of the other medicines that I take.

I agree not to drive, carry or use a firearm, operate dangerous machinery, or serve**,** in any capacity related to personal and public safety, if I feel impaired, tired, or confused.

I understand that it is possible to be cited for driving while impaired if a law enforcement officer finds that I am operating a motor vehicle while mentally impaired by my medication.

10. I understand that I may experience physical withdrawal symptoms (headache, nausea, vomiting, chills, diarrhea, muscle aches, and malaise) if I take opioid medications for more that a few months and then abruptly stop taking them. I understand that I can stop opioids without withdrawal symptoms if I taper the medicine slowly under a doctor's care. I understand that serious dehydration and chemical imbalance can occur if I go through withdrawal and cannot eat or drink for a prolonged period. I agree to seek help in an emergency room or urgent care center if this should occur.

11. I understand that it is possible to develop "addiction" (psychological dependence) to opioids, but that this is fairly uncommon. My doctor will be monitoring for this and will take appropriate action should the warning signs of addiction appear**.**

12. If I am a woman, I acknowledge that the effect of Opioids during pregnancy is potentially harmful to both mother & fetus. *To the best of my knowledge, I am presently not pregnant. I will notify my physician if I do or plan to become pregnant while taking opioid pain medication.* Opioids are classified as category C in pregnancy (there is un-known safety, animal studies have shown an adverse effect, and there are no human studies).

13. I understand and give my consent that my doctor, at his or her discretion, may discontinue opioid pain medication if I do not follow my plan, if I do not treat the office staff with reasonable respect, or if he/she believes that my treatment with opioid pain medication is or could be harmful to me.

PHYSICIAN RESPONSIBILITY:

As Your Surgeon:

1. Staff members and I will treat you with courtesy and respect.

2. I will listen carefully to you when you describe your concerns, answer all of your questions, and do so using language you can understand. Please tell me if I further detail is required or you need more information.

3. I will do my best to give you adequate pain medication so that you will not suffer unnecessarily. Finding the proper medication and correct dosage may take some time and restrictions of dosage may be required to avoid harmful side effects. My office will make every effort to handle your prescription refills in an orderly and efficient manner.

5. You may bring another person to your appointments and, with your consent, I will take the time to explain the conditions of this agreement to them, why I am prescribing opioid pain medications, and your treatment plan.

6. As your condition improves, opioid therapy should be discontinued, I will devise a safe and comfortable taper schedule for you to follow. Every effort will be made to complete this process within the usual period of 90-120 days. If the process will take longer than this time frame or a chronic narcotic regimen is required, I will refer you to a Pain Medicine Specialist. This process may also include the prescribing of additional medications, so that withdrawal symptoms, if present, will be lessened.

7. If you and I conclude we cannot establish a working patient-physician relationship*, for whatever reason,* then I will provide you with a list of appropriate physicians (except in case of emergency). Further, I will prescribe sufficient medications for a reasonable period of time, unless the patient responsibility terms of this agreement have been violated, to allow establishment of care with your new physician.

_____	_____
PATIENT	**PHYSICIAN**
DATE: _____	DATE: _____