

Narcotic Agreement

In the course of my treatment my physician may prescribe a painkiller/sleeping medication. While these medications are generally safe and effective, certain guidelines must be followed in order to absolutely minimize any risk of dependency, addiction or other complications.

The guidelines are:

1. I understand that narcotics are used during an acute period (two weeks to two months). Any prescription beyond this period can put me at risk for medical issues and can best be monitored by my primary care physician or a pain clinic.
2. I am aware of the possible complications that can be masked by pain medicine. Example: fever, chills, increased pain, and swelling.
3. I will not drink alcohol, drive or operate machinery while taking this medication.
4. I agree to have urine tests for medications and street drugs if the doctors ask for it.
5. I agree I will not use any illegal controlled substances, including marijuana, cocaine, Heroin, etc. I agree I will not use any prescription medications obtained illegally or obtain them from friends or relatives.
6. I authorize University Orthopaedic to cooperate fully with any official, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine.
7. I understand that if I or a family member are verbally or physically abusive to any staff member or engage in any illegal activity such as altering a prescription, that the incident may be reported to other physicians, local medical facilities, pharmacies and other authorities such as the local police department, drug enforcement agency, etc. as deemed appropriate for the institution.
8. My doctor dispensed a specific quantity to last me a specific amount of time. If I am told to take one pill every six hours, and instead I take two pills every six hours, I will run out before my next prescription, and I will be without this medicine for a period of time.
9. My doctor or his associate will refill my medicine only:
 - If I am actually due to have the medicine refilled.
 - If I keep all scheduled appointments with my doctor **and** Physical Therapy.
 - During regular office hours (8:30 a.m. – 4:00 p.m.) and **not** on weekends, holidays, or after 4:00 p.m. on weekdays.
6. If I am due for a refill before my next appointment, I should call three days ahead of time.
7. I will have the medication and any subsequent refills filled at this pharmacy:

Name: _____ Phone Number: _____

8. I am expected to keep my medicine in a safe, secure place where the chance of theft is minimal. If my medicine is stolen, it will not be refilled before the next due date. My doctor recommends that I hide at least half of my medicine in a safe place.
9. While under the care of UC Health Orthopaedics, I will not seek or receive pain medications / sleeping pills from any other physician without the prior consent of UC Health Orthopaedics. To do so will result in these medicines no longer being prescribed.

I have read carefully, understand and agree to the above stated guidelines. Failure to comply with these guidelines may compromise my health, your ability to care for me properly, and may result in possible dismissal from care.

Patient Name

Patient Signature

Date

Date of Birth