Casscells
ORTHOPAEDICS & SPORTS MEDICINE

Our goal at Casscells Orthopaedics & Sports Medicine is to treat patient's pain and to improve functional ability. We try to achieve these objectives without the use of narcotic medications. We attempt to avoid narcotic medications because these substances are highly addictive, commonly resulting in dependency. Furthermore, patients develop tolerance to these medications often requiring higher dosages. Our practice requires that you sign this pain medication contract in case you and your physician determine that narcotic medications will be used in your treatment. It is important that you have an understanding of the significant risks and responsibilities that go along with treatment with narcotic medications. Please **read each statement and sign this agreement/contract below.**

I, _____, understand that:

- I am aware that use of pain medications has certain risks. Including but not limited to; addiction, impaired judgment, sleepiness and/or confusion, constipation, nausea, vomiting, allergic reactions, overdoses, breathing problems, dizziness, lowered blood pressure, sexual problems and possibly that the medication **will not** provide complete pain relief. The goal of treatment is to reduce my pain to a level that is tolerable and will allow me to function from day to day. This may require carful use of the pain medications together with a variety of each treatment. These may include other types of medications, nerve blocks, physical therapy, changes in my activity, TENS unit, or acupuncture.

- I will use one provider to prescribe medication for me. I will not attempt to obtain any pain medications, controlled stimulants or anti-anxiety medications from any other provider. If I seek a prescription for pain medications from another provider/facility, this will break my contract and this office will no longer prescribe my medications.

- I will use one pharmacy to have my prescriptions filled. I will use the following pharmacy:

  Pharmacy Name_____ Phone Number: _____

  Address_____

- I agree to participate in **RANDOM DRUG SCREENING TESTS** in order to determine effectiveness and compliance with my pain medications. If I decline to participate in this screening, this office will no longer prescribe my medications.

- Medications **will not** be replaced if they are lost, stolen, get wet, are destroyed, left somewhere etc. I will take the highest possible degree of care with my medication and prescription.

- I agree that refills for pain medications will be made only at my office visit or on the medication refill line. There will be no early refills and refills will not be available during evening hours, or weekends.

- I will communicate fully and honestly with my provider the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to relieve the pain.

- While this contract is in effect, I will not use any illegal substances, including marijuana, cocaine, heroin, etc. I will not sell, give my medications to others, misuse, or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to times when I am not driving or operation machinery and will be infrequent. If illegal substances are found during screening, I will be reported to the authorities.

- I understand that if I break this agreement/contract, my provider will stop prescribing these pain medications and that my treatment may be terminated.

  Patient Signature: _____Date:_____