

**Emory Healthcare Treatment  
Agreement for Controlled Substance Prescriptions for Chronic Pain**

Controlled substance medications (i.e., opioids, or narcotics, tranquilizers, stimulants and barbiturates) are very useful but have a high potential for misuse and are closely controlled by local, state and federal governments. They are intended to relieve pain, thus improving function and/or ability to work. In the event that the following Emory Healthcare Provider and Practice

MD \_\_\_\_\_ at practice location: TEC Family Medicine, Dunwoody, Ga. were to prescribe controlled substance medications for pain, I agree to abide by the following conditions:

1. I agree to use one pharmacy for all controlled substance medications. I understand that all controlled substances for treatment of pain must come from the Emory provider listed above unless specific authorization for an exception is obtained from this provider. Obtaining controlled substances from multiple sources can lead to untoward drug interactions or poor coordination of treatment. Should the need arise to change my pharmacy, I will notify the Emory provider listed above. The pharmacy I have selected is:

Phone: \_\_\_\_\_

2. I understand that I am responsible for the controlled substance medications prescribed to me. I agree not to share, sell or otherwise permit others including spouse or family members to have access to these medications. Prescription medications may be sought by individuals with chemical dependency and should be safeguarded. I will not leave medications where others might have access to them.
3. I understand that there are risks associated with chronic narcotic/opioid consumption. There may be associated drowsiness. This is usually worse at the beginning of narcotic/opioid therapy and tolerance generally develops to this side effect. I may have difficulty concentrating which may affect my ability to operate heavy machinery and to drive. I am not to operate heavy machinery or to drive if I feel impaired at any time. There is a risk of physical dependence and if I am on a large dose of narcotic/opioid and abruptly discontinue the medication I will likely experience withdrawal symptoms. There is a risk of behavioral changes associated with narcotics/opioids. Constipation is very common and may be treated by dietary changes, stool softeners and intestinal stimulants.
4. I understand that if I experience a change in my pain levels, I will make an appointment for an office visit. I will contact the Emory provider listed above and receive approval before making any pain medication changes. I will inform the Emory provider listed above of any new medications or medical conditions, and of any adverse effects or side effects I may experience from any of the medications I am taking.
5. I understand that refills of controlled substance medications will be made during regular office hours, Monday through Friday, in person, during a scheduled visit. Refills will not be made at night, weekends, or holidays. Refills will not be made if I "run out early," "lose a prescription" or as an "emergency." I am responsible for taking medication in the dose prescribed and for keeping track of the amount remaining. Early refills will generally not be given. I will call at least 72 hours ahead if I need assistance with my refill.
6. I understand that it may be deemed necessary by my Emory doctor that I see a medication-use specialist at any time while I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medication may be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the specialist feels that I am at risk for addiction or psychological dependence, my medications will no longer be refilled.
7. I agree to not consume excessive amounts of alcohol in conjunction with narcotics, nor will I use, purchase or otherwise obtain any illegal drugs.
8. I understand that if the responsible legal authorities have questions concerning my treatment, as might occur, for example if I obtained medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to my Emory Healthcare records of controlled substance administration. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide me healthcare for purpose of maintaining accountability.
9. I agree to comply with unannounced, random urine, blood (or serum), saliva, sweat or breath testing, for documenting the proper use of my medications as well as confirming compliance. Presence of unauthorized substances may result in discharge from the Emory practice involved in my care.

Patient Initials \_\_\_\_\_

Date \_\_\_\_\_

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10. I agree that I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might be slowed. Performance of activities that could be impacted include but are not limited to: using heavy equipment or motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.
11. I understand that any medical treatment is initially a trial, and continued prescriptions are contingent on evidence of benefit. I understand that the main treatment goal is to reduce pain and improve my ability to function and/or work. I must also comply with the treatment as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.
12. I understand that if I violate any of the above conditions, obtain my prescription for controlled substance medications from another individual, or concomitantly use non-prescribed illicit (illegal) drugs, I may also be reported to all my physicians, medical facilities and appropriate authorities.
13. I understand the long-term advantages and disadvantages of chronic opioid (narcotic) use have yet to be scientifically determined, and my treatment may change at any time. I understand, accept and agree that there may be unknown risks associated with the long-term use of controlled substances, and that my physician will advise me of any advances in this field and will make treatment changes as needed.
14. I understand that all controlled substances have the potential for abuse, tolerance, physical dependency, psychological dependency and addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family. Tolerance to the medication may develop after long-term use, which means that ultimately this medication may become less effective. If tolerance occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment. I know that it may be necessary to stop the medication. If so, I know I must slowly decrease the dose while under medical supervision or I may have withdrawal symptoms.
15. Risks and benefits of these therapies were explained to me and are outlined in this consent form. I had an opportunity to ask questions and questions that I had were answered to my satisfaction. By signing this form I give consent to my physician to prescribe narcotics/opioids as part of the treatment of my pain.

**I affirm that I am at least 18 years of age and that I have read, understand, and accept all the terms of this agreement. In addition, I fully understand the consequences of violating this agreement may include cessation of therapy with controlled substances and/or discharge from the Emory practice in which I receive my care.**

Patient Name (printed) \_\_\_\_\_

Patient D.O.B. \_\_\_\_\_

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Physician Signature Date

\_\_\_\_\_  
Witness Signature Date