Narcotic Agreement

Consultants in Pain Medicine
Mark Moran, M.D.
Phone: 210-546-1470 **Fax: 210-546-1479**

I, _____ (Print Name), am receiving opioids (narcotics) to treat the following chronic pain condition: _____. The purpose of this agreement is to protect my access to controlled substances for the treatment of my pain.

I understand that there are risks associated with opioid treatment, such as physical dependence, ADDICTION, change in personality, sleep changes, respiratory depression, nausea, constipation and even bowel obstruction, changes in appetite, coordination, decreased testosterone, sexual desire and performance and death. Stopping opioids suddenly can lead to rebound pain and to withdrawal symptoms. I have been informed not to stop my opioid medication suddenly.

Medication and other drug interactions can increase the risk of taking opioids. I agree to keep you up to date and informed regarding any medication changes that I may receive from any other doctor. I agree to inform you of my drinking practices so that we can discuss the risks of alcohol consumption. I also agree not to use any illegal drugs including Marijuana. If I smoke cigarettes, I agree to discuss with you the desirability of quitting smoking.

To minimize risk and assure adequate supervision, I agree to come in for regular visits every **three (3) months**. Failing to do so may result in a weaning dose of medications. I agree to have any labs you advise, including random drug blood levels and urine drug screens. I agree to come in on a short notice for random pill counts to help assure I am taking my medications in the prescribed manner. I agree to report any changes in my mental state or any adverse reactions. I agree to see any specialists you deem necessary.

I agree not to obtain any opioids from any other physician unless you are notified, even if I am having a surgery of any kind, I will let you know ahead of time if possible. I agree not to obtain any opioids from friends or other people. I will get my medications from only one pharmacy, and will inform you of any change in my pharmacy. I will not give or sell my opioid medications to anyone else to use, not even my family. I will keep my medications in a safe, secure place to prevent theft, loss or accidental ingestion by other individuals (children).

If my opioid medication is lost, stolen, destroyed, etc…or used up early, I understand that it will ***NOT BE REPLACED OR REFILLED*** until the date of my next regular refill. I agree to NOT change my dose (self escalate) without first discussing it with you, either by phone or in person. I understand that it is my responsibility to plan ahead and call in my prescriptions to the office 3-5 days ahead of time in order to give you ample time to authorize a refill for me. I agree not to destroy my opioid medication without first discussing it with you. I agree to make efforts to improve my functioning, and if I do not, I understand that my medications may be discontinued. I understand that medications are not filled after hours, weekends or holidays.

Patient: _____ Witness (office staff) _____

Date: _____