Philadelphia Health Associates-Adult Medicine
1740 South Street, Suite 300
Philadelphia, PA 19146

CONTROLLED SUBSTANCE and PAIN MANAGEMENT INFORMED CONSENT FORM

The purpose of this Agreement is to help educate you about use of narcotics in pain management and to comply with the law regarding controlled pharmaceuticals. Read and initial each item and return to your physician for review.

_____ I understand that use of controlled substances/narcotics for may cause impairment and death.

_____I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor will provide treatment based on this Agreement.

_____I authorize my doctor to review current and past history of controlled substance and pain management or controlled record for entrance or continuing pain management treatment. New patients must provide old records.

_____I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

_____ I understand that using illegal controlled substances such as marijuana, cocaine, heroin, etc. increases risk to my health and can interact with medication prescribed. Urine drug tox screen will be done periodically.

_____I will not share, sell or trade my medication with anyone.

_____I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor.

_____I will safeguard my pain or controlled medicine from loss or theft. Lost or stolen medicine will not be replaced.

_____I agree that refills of my prescriptions for pain or controlled medicine will be made only during regular office hours. I must give notification 3 business days before refill is due.

_____I agree that I will make an office visit appointment every three months for continual assessment and treatment. Please make follow-up appoint prior to leaving office.

_____I agree that I will comply with the agreed upon controlled substance and/or pain management program including medication dosing and referral to physical therapy and specialists, if prescribed.

_____I agree that I will submit to a random blood or urine test, if requested, by my doctor to determine my compliance with my program of pain control medicine or other chronic conditions.

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_____I agree that I that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

_____I understand that controlled substances will not be prescribed before the due date.

_____I understand that I must notify office 3 business weekdays prior to refill is due.

_____I will bring all unused pain medicine to every office visit.

_____I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. The policy is one doctor, one pharmacy.

_____I understand that if I break this Agreement, my doctor will stop prescribing these pain-control medicines.

_____In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended. No tapering will occur if no prescribed drug is in my system.

_____I fully understand and agree to follow these guidelines and understand that failing to sign this Agreement is a decision by me not to participate in the controlled substance and/or pain management plan.

_____ I agree to use one pharmacy: Name_____.
Location_____

_____I understand that if I do not agree to each point above, pain management cannot be continued by Dr. Warren and plan to taper or referral to pain management will occur.

_____I understand that I can ask questions about this agreement.

_____I am asking for a copy of this document. It will be part of my medical records.

This Agreement is accepted on (mm/dd/yyyy) _____.

Patient name printed: _____

Patient Signature Required: _____
Reviewing Provider Signature Required for Approval: _____