OKLAHOMA SPINE SPORTS & REHABILITATION

a division of Neuroscience Specialists
4120 West Memorial Road, Suite 118 Oklahoma City, Oklahoma 73120
405.748.4700 Fax 405.748.5638
www.ossrokc.org

A.J. Bisson, MD
Michael S. Brown, MD
Kimberly A. Bouvette, MD
Christopher M. Bouvette, MD

CONTROLLED SUBSTANCE TREATMENT AGREEMENT

I. Informed Consent
   a. Goal: Reduction of pain, improvement in function and improvement in quality of life.
   b. Controlled substances have many potential side effects that may result in health related issues and pose a safety risk to you and others.
   c. Risks include but are not limited to: decreased reaction time, clouded judgment, drowsiness, tolerance, nausea and vomiting, constipation, dry mouth and difficulty breathing. Opioid medications may also result in problems with judgment, coordination, and/or balance that may make it unsafe to mix opioids with other drugs, including alcohol. Additional risks include physical dependence (which may lead to withdrawal if the medication is stopped abruptly), psychological dependence, tolerance and addiction.

II. Treatment Agreement
   I understand that I have the following responsibilities:
   a. I will take the medication only at the dose and frequency prescribed.
   b. I will not increase or change medications without the approval of my physician.
   c. I will actively participate in return to work efforts and in my program designed to improve function (including social, physical, psychological, and daily or work activities)
   d. I will not request opioids or other pain medicine from any other physician.
   e. I will inform my physician at Oklahoma Spine, Sports, and Rehabilitation of all other medications that I am taking.
   f. I will obtain all medications from one pharmacy. I agree to use ____________________ pharmacy, located at ________________________ for all medications. I give my physician full consent to talk with the pharmacist by signing this document.
   g. I will protect my prescription and medications. If the prescription or medication is lost, misplaced, stolen, or if I use it up too quickly, it is gone and will not be replaced. I will keep all medications out of reach of children.
   h. I agree to participate in psychiatric or psychological assessments, if necessary.
   i. I will not use alcohol and illegal or street drugs

III. I understand that I will consent to random drug screenings. A drug screen is a laboratory test in which a sample of my urine is checked to see what drugs I have or have not been taking.

IV. I will keep my scheduled appointments as per the policy of Oklahoma Spine, Sports, and Rehabilitation.

V. I understand that my doctor may stop prescribing opioids or change the treatment plan if:
   a. I obtain a medical marijuana patient license or am taking medical marijuana.
   b. I do not show improvement in pain from opioids or physical activity is not improved.
   c. My behavior is inconsistent with the responsibilities outlined above.
   d. I give, sell, or misuse the opioid medications.
   e. I develop rapid tolerance or loss of improvement from the treatment.
   f. I obtain opioids from a source other than this office.
   g. I refuse to cooperate when asked to get a drug screen.
   h. I am unable to keep the follow-up appointments.

I understand that if I violate any of the above instructions and conditions or decline to take a blood or urine test for controlled substances at any time, my narcotic prescriptions or my entire treatment at Oklahoma Spine, Sports, and Rehabilitation may be terminated. If the violation is serious, it may be reported to my primary care physician, local medical facilities, and other authorities as appropriate.

______________________	______________________	______________________
PATIENT SIGNATURE	WITNESS SIGNATURE	DATE