Patient Name: _____ Date of Birth: _____

UNIVERSITY CENTER FOR PAIN MANAGEMENT of KNOXVILLE
CONTROLLED SUBSTANCES THERAPY AGREEMENT

The purpose of the agreement is to protect your access to controlled substances and to protect our ability to prescribe for you. The long-term use of such substances as opiods (narcotic analgesics), benzodiazephine tranquillizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason, you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain agree to the following policies.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to drug interactions or poor coordination of treatment.)
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies our office must be informed. The pharmacy that you have selected is: _____

   _____
3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.
5. You may not share, sell, or otherwise permit others to have access to these medications.
6. The drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
7. Unannounced urine screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.
8. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.
9. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
10. Medications may not be replaced if they are lost, get wet, are destroyed, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.
11. Early refills will generally not be given.
12. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.
13. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
14. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substances.
15. Renewals are contingent on keeping scheduled appointments. (Please do not phone for prescriptions after hours or on weekends.)
16. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.
17. The risks and potential benefits of these therapies have been explained to you and your signature acknowledges that you have received such an explanation.
18. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date