GARFIELD COUNTY HOSPITAL DISTRICT-POMEROY CLINIC PAIN AGREEMENT-CONTRACT (attachment B)

CONTROLLED SUBSTANCE CHRONIC PAIN AGREEMENT

Patient name: _____ Date: _____
Provider: _____ Date: _____

Medication: _____
(To be completed by provider; include name of medication, dose, frequency, route, diagnosis, # of tabs, & # refills)

Scheduled pain and function assessments: _____
(Assessments to be scheduled at time of pain agreement; at least every three months or as identified)

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe to you.

The long-term use of controlled substances such as: opioids, benzodiazepine tranquilizers and barbiturate sedatives are controversial due to the uncertainty regarding the extent to which they provide long term benefit. There is the risk of an addictive disorder developing or of a relapse occurring in a person's prior addiction. The extent of this risk is not certain.

Due to the potential for abuse of these drugs strict accountability is necessary when use is prolonged. For this reason the following directives will be agreed upon by you the patient and the ordering provider whose signature appears below.

1. All controlled substances will come from only the GCHD provider listed above, or another GCHD provider if needed. GCHD providers will coordinate care, prescriptions and the treatment plan of the identified patient.
2. All controlled substances will be obtained at the same pharmacy. If you need to change pharmacies the patient will schedule an appointment with provider at the Pomeroy Medical Clinic and update information. The pharmacy you have selected is: Pharmacy: _____ Phone: _____
3. You are required to inform provider of all medications and treatments you are receiving.
4. You are required to inform the GCHD providers immediately of any change of medical conditions, medications, or adverse effects you experience from any of the medications you currently use.
5. You are required to complete a consent form so the GCHD providers may discuss all diagnostic and treatment details with dispensing pharmacists, other health care professionals or law enforcement agencies. If you are found to be receiving medications from several pharmacies all confidentiality is waived and law enforcement agencies will be given full access to your record of controlled substances.
6. You may not share, sell, or otherwise permit other individuals to have access to the medication listed above.
7. These medications should not be stopped abruptly as an abstinence syndrome could develop.
8. Unannounced urine or serum toxicology screens may be required from you. The presence of unauthorized substances may prompt a referral for addictive disorder.
9. You are required to safeguard controlled substance medications. Do not leave medications where others might see or have access to them. These medications may be hazardous or lethal to a person who is not tolerant to their effect, especially children. You are responsible to keep medications out of the reach of children.
10. Original medication containers will be brought to the Pomeroy Medical Clinic for each schedule appointment.
11. Medications will not be replaced if they are lost or destroyed. The only possible exception is if medications are stolen and you present to the Pomeroy Medical Clinic with a completed police theft report. The prescription may be replaced at the provider's discretion.
12. Early refills will not be given. Prescriptions will be refilled only at scheduled appointments. Do not phone after hours or for refills.
13. The medical treatment identified in this agreement is an initial trial and continued treatment is contingent on evidence of benefit.
14. Your signature on this document signifies your understanding that failure to adhere to these standards may result in cessation of therapy with the controlled substance as prescribed by this provider or referral for further speciality assessment; you under the risks and potential benefits of this treatment as explained to you; that you affirm that you have the full right and power to sign and be bound by this agreement; and you have read, understand and accept the terms of this pain agreement.

Patient signature: _____ Date: _____

Provider signature: _____ Date: _____

Information recorded in program by: _____ Date: _____