

**Lakeshore Bone and Joint Institute
Controlled Substance Agreement and Informed Consent**

Controlled substance medications (opioids, tranquilizers and barbiturates) are very useful but carry a high potential for misuse. They are therefore closely controlled by the local, state and federal government. Physicians are under constant scrutiny regarding the prescribing of these medications. The medications are intended to relieve pain, improve function and/or ability to work and are not for recreational use. Because my physician is prescribing such medications to manage my pain, I agree to the following conditions:

1. I am responsible for my controlled substance medications. If the prescription is lost, misplaced, stolen, disappears for any reason, I understand that it will not be replaced.
2. I understand that if I do not take my medication as directed, or if I run out of medications early, they will not be replaced.
3. I will not request or accept controlled substance medications from sources (physicians, clinics, etc.) other than the Lakeshore Bone and Joint Institute Pain Management Physician. The only exception is medications prescribed while admitted to the hospital.
4. I may be required by my physician to undergo periodic drug testing.
5. I may be required by my physician to complete a psychological evaluation and participate in psychologically based pain management therapy.
6. Refills of controlled substance medications:
 - a. Will be made only during the LBJI Pain Center's regular office hours and must be picked up in person. Refills will not be made at night, over weekends or on holidays.
 - b. Will NOT be made if I "run out early". I am responsible for taking the medications in the dosage prescribed and for keeping track of the remainder.
 - c. Will NOT be made as an "emergency". Prescription refills must be requested at least 48 hours prior to anticipated pick-up of the prescriptions.
7. I understand that any changes in medications will need to be made during your visit with the physician and not via telephone. Any questions regarding the dosage are to be directed to the nurses initially.
8. I understand that if medications need to be discontinued, this will be done gradually and under medical supervision. Certain medications may be dangerous if you stop taking them abruptly and may lead to withdrawal symptoms.
9. I understand that taking these medications may alter my ability to drive and operate heavy equipment and these issues, if applicable, should be discussed with your physician.
10. In understanding that if I violated any of the above conditions, that my controlled substance prescriptions and/or treatment at LBJI may be ended immediately and that I may be reported to other treating physicians, pharmacists and/or other authorities.
11. I understand that the main treatment goal is to improve my ability to function and/or work. In consideration of that goal and the fact that I am being given potent medications to help me reach that goal, I agree to help myself by engaging in the following better health habits: regular exercise, weight control and the non-use of tobacco. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

I have been informed by LBJI and staff regarding the psychological dependence and/or addiction that may occur in some people taking controlled substance medications. I have been informed that some patients become tolerant of the medications and may need to adjust the dose to achieve the same level of pain control and that physical dependence may develop. I agree that if I want to stop the medications, I will do so under a physician's supervision or I may have withdrawal symptoms.

I have read this agreement and I have had any questions answered by the staff regarding the terms of this agreement. I fully understand the consequences of violating this agreement, and if I do, I will forfeit my ability to obtain controlled substance medication through the LBJI pain center and my treatment will be terminated. I understand that it the sincerest wish of the staff at LBJI Pain Center that the treatment of pain is as successful as possible and we are working as a team to achieve that goal.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

LBJI Physician Signature _____ Date _____