

CLINICAL NEUROSCIENCES OF TAMPA BAY, LLP

430 Morton Plant Street, Suite 400 Clearwater, Florida 33756
727-443-3295 FAX 727-446-4336

MEDICATION & CONTROLLED SUBSTANCE/PAIN AGREEMENT

This is an agreement concerning the use Medication prescribed from our office. Medications prescribed are for the use of the patient and not to be shared.

If prescribed a controlled medication including opiate (narcotic) drugs I agree to the following. The purpose of prescribing controlled medications including opioids is to improve function or reduce pain. If medication loses its effectiveness it will be tapered. There is a risk of an addictive disorder or a relapse in a person with a prior addiction. I understand that if I *break this Agreement, my doctor will stop prescribing controlled medications.*

Risks of controlled medication include emotional and physical dependence (rare, 1 in 10,000), side effects of constipation, difficulty with urination or sexual function, nausea, itching, and mental clouding. Controlled medication including opiate drugs taken with alcohol or street drugs can causes serous side effects including organ damage or death.

I agree to the following if using Controlled substances:

1. I will not use any illegal controlled substances, including marijuana, cocaine, etc.
2. I will not share, sell or trade my medication with anyone. I will keep medications safe (out of sight and access to others) and out of reach of young children.
3. I will not attempt to obtain any controlled medicine including opioid pain medicine, controlled stimulants, or anti-anxiety medicines from any other doctor.
4. I will safeguard medicine from loss or theft. Lost or stolen medicines are not replaced. I agree to report to the police and file a police report for lost or stolen medication.
5. I agree refills of prescription for pain medicine will be made only during an office visit and during regular office hours (prior to noon on Friday). No refills after hours.
6. I agree to use only one pharmacy location to refill pain medicine.
7. Telephone refills of medications are not given. Early refills will not be given.
8. Renewals are contingent on keeping scheduled appointments.

I further agree to the following:

1. I will bring all unused pain medicine to each office visit when requested.
2. I will use my medicine at a rate no greater than the prescribed rate and use of my medicine at a greater rate will result in my being without medicine for a period of time.
3. I agree that if I become pregnant, decide to become pregnant, or nursing while taking medications prescribed, I WILL INFORM THE DOCTOR IMMEDIATELY.
4. Drugs should not be stopped abruptly, a withdrawal may occur.

I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to wave any applicable privilege or right of privacy or confidentiality with respect to these authorizations. I agree I will submit to a blood or urine test if requested to determine my compliance with my program of pain control medicine. I agree to follow these guidelines. The guidelines have been fully explained to me; I have had my questions and concerns adequately answered. A copy of this document will be provided to me if requested.

NAME: _____ Signature: _____

Witnessed By: _____ Date _____