Primary Health℠
Medical Group

Narcotics Contract

Patient:_____ Date: _____

The purpose of this contract is to define the expectations between the prescriber, Dr. _____, and the patient regarding the use of narcotic medications.

I understand that I have a chronic pain syndrome requiring the use of narcotics for the control of the pain. In addition, I understand that the use of chronic narcotic medication carries the risk of addiction as well as side effects from the medication. I understand that narcotics may impair my ability to operate a motor vehicle or heavy equipment.

In order to reduce the chances of abuse of the medication, certain parameters regarding the prescription are agreed to:

1. I will not use the medicines at doses higher than prescribed.
2. I will not ask for or receive narcotic prescriptions from other medical providers, except as authorized by my physician.
3. I will not ask for early prescription refills except under the most adverse conditions.
4. No replacements will be provided for lost medications or prescriptions.
5. If an early refill is granted for reasons of travel, etc., the next refill will be delayed by an amount of time equal to the number of days early the refill is given.
6. I understand that my physician will need to see me for regularly scheduled visits to follow up on my chronic pain issues. It is my responsibility to schedule the appointments so that I do not run out of medication.
7. I will request medication refills as least 3 business days ahead of the time I will run out.
8. I agree to release information from all pharmacies where I obtain medications. I will choose one pharmacy to fill my pain medications and I will notify my physician if I change pharmacies.
9. I will consent to random drug testing.
10. No refills will be made at night, on holidays or weekends. I will not request refills from on-call physicians.

I have been informed that I may not take other drugs such as tranquilizers, sedatives, or antihistamines without first consulting with my physician. I understand that I should not mix my medications with alcohol. The combination use of the above drugs may produce profound sedation, respiratory depression, and in worst cases, death.

Failure to abide by these parameters will be grounds for termination of the prescription of narcotics by Dr. _____ and may result in termination from this practice.

Medication: _____ Dosage:_____ Monthly Quantity:_____

Pharmacy: _____ Telephone #: _____

I have read, understand and agree to follow the rules of this agreement. I authorize a copy of this agreement to be released to my pharmacist.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____