

AGREEMENT FOR NARCOTICS AND OTHER DANGEROUS MEDICATIONS

This is an agreement between _____
(me, the patient), and the staff of the Northern California Neurosurgical Medical Group, Inc. (my doctor). **It explains how** I will receive my pain medications, muscle relaxants, sedatives, sleeping medications and other dangerous drugs. It lists my responsibilities. I agree to take my medications responsibly and to follow all of my doctor's orders.

These medications are intended to help my pain and function. No medication will get rid of all pain. I will have some pain and, perhaps, some side effects. I know that pain medications, sedatives, muscle relaxants, sleeping pills, narcotics, tranquilizers, and barbiturates are all dangerous. They can be abused. If misused, they can even kill.

I have discussed the use of my medications with my doctors. I have received written information about each of my medications. All of my questions have been answered. Drugs are just one of the options available to me and I understand the risks, benefits and **alternatives.**

1. I agree to use the following pharmacy only:
_____, in _____ city,
at _____ telephone.

2. I will attend all of my **doctor's** visits and will come in immediately if asked.
3. I will not go to the emergency room for medications.
4. I will not get medications from other doctors.
5. I am personally responsible for all of my medications. I will treat my medications as my other valuables. I understand that medications may not be replaced if they are lost, get wet, or are destroyed.
6. I will not give my medications anyone else or take anyone else's drugs.
7. I will not request early refills.
8. For safety reasons, refill requests can only be honored only during office hours.
9. I will inform the doctors of any new medications or medical conditions.
10. I agree to allow my doctors to perform any urine, blood, or breath testing needed to make sure I use of my medications correctly.
11. I will not drive a car or use dangerous equipment when I use my pain medication, or other dangerous medications.
12. It is my responsibility to comply with all laws and rules while taking these medications.
13. I will not use any alcohol or illegal drug when using these medications.
14. My doctors may discuss my medications with any relatives, friends, caregivers, doctors, pharmacists, insurance companies or others to insure **safety.**
15. I understand that there can be side effects from these medicines (and all other medications). These side effects can include sedation, itching, nausea, vomiting, difficulty urinating, constipation, and other undesirable problems.
16. I understand that I may become addicted to these medications.
20. I understand that suddenly stopping these medications may be dangerous.
21. If I violate these conditions, the doctors may not refill the drugs or may require that I obtain help to decrease my use of these medications.

22. I know that violating these conditions may also result in my dismissal from the doctor's practice.

22. I further agree that my pain medication or other prescriptions may be stopped or decreased at any time, for any reason, by my doctors.

Finally, I understand that the above is not a complete list. I will be careful and will exercise caution and common sense. I will ask questions if I do not understand something or if I feel that I may be having trouble with the medication.

Patient's Signature_____

Date_____

Adapted from the American Academy of Pain Management Consent Form