



Patient name: _____

AGREEMENT FOR CONTROLLED SUBSTANCES

We want to help you restore function and help control your pain. To achieve those goals this office is willing to prescribe controlled substances. Controlled substance medications (i.e., narcotics, opiates, sedatives, and barbiturates) can be very useful, but have a significant potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain and to improve both function and ability to work. Because this office assumes additional risk by our willingness to prescribe these medications, we ask that you read and agree to the following conditions. Signing this agreement does **NOT** indicate that you want these medications nor that we will necessarily prescribe them for you.

If I checked this box, I do not want controlled prescriptions. However, if I ever get controlled medications I agree to these provisions.

- ____ 1. I am responsible for my medications. I understand that people may try to take these from me. I will take measures to secure them and to prevent theft. If the medications are lost, misplaced, or stolen, **REGARDLESS OF THE REASON,** I understand they **WILL NOT** be replaced or refilled and I risk being discharged from care.
- ____ 2. I **WILL NOT** request nor accept medications from any other physician or individual while I'm receiving medications from Dr. Radnovich. Besides being illegal to do so, it may endanger my health. The only exceptions are medications I am already taking **THAT I HAVE TOLD Dr. RADNOVICH ABOUT;** or medications prescribed while I am admitted to a hospital.
- ____ 3. Concerning refills: refills of controlled medications will be made during regular office hours, in person, during a scheduled visit. Refills will not be made of I "run out early". I am responsible for taking the medications as prescribed and for keeping track of the amount remaining. Early refills will not be made if I have had a new injury. If I have a new injury I will make an appointment to be seen.
- ____ 4. I will call at least 24 hours but no more than 48 hours before my medications will run out, to arrange for refills.
- ____ 5. I **WILL NOT** discard, flush down the toilet, give away or in any way loose control of medications, **INCLUDING MEDICATIONS THAT I NO LONGER USE.** I will bring in all the medications in their original containers (including the unused portions) each office visit, even if there is no medication remaining.
- ____ 6. I **WILL NOT** give, sell or in any manner allow anyone to use or obtain medications prescribed for me. Besides being illegal to do so, it may endanger health of those taking my medications.
- ____ 7. I **WILL TAKE** the medications as prescribed and directed. Improper use can cause death. It is my responsibility to inform Dr. Radnovich about the success or failure of treatment so he can make appropriate adjustments in my medications.
- ____ 8. I understand that the main treatment goal is to improve my ability to function and/or work, not simply to reduce pain. I agree to help myself by following better health habits like regular exercise, weight loss as recommended, and not using tobacco or alcohol. I understand that following a healthier lifestyle will help me reduce my pain and improve function.
- ____ 9. I will not use any illicit drugs, as defined by law. These include marijuana, heroin, methamphetamine, cocaine, PCP and hallucinogens
- ____ 10. I will not drive or use machinery or dangerous equipment if I am feeling tired or impaired, or if I have been told that I am impaired.
- ____ 11. In order for Dr. Radnovich to monitor my compliance with proper medication use, I agree to drug testing. I also waive certain privacy rights, including talking with other health care providers, family members and, if necessary, law enforcement officials. In addition, I will come into the office when asked for testing and to produce unused portions of medications to verify they are being taken as directed.
- ____ 12. I have been fully informed by Dr. Radnovich and/or his staff regarding psychological and physical dependence to controlled substances. I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the same level of pain control. I also know that I may become physically dependent of the medication and stopping the medications suddenly may cause serious withdrawal symptoms.
- ____ 13. I understand that if I violate any of the above conditions, my controlled substance prescriptions and/or treatment with Dr. Radnovich may be immediately terminated and I risk experiencing withdrawal symptoms. If the violation involves obtaining or giving someone controlled substances, I may also be reported to my other healthcare providers, medical facilities, and law enforcement officials.
- ____ 14. I have read this agreement. It has been explained to me by Dr. Radnovich and/or his staff. I fully understand the consequences of violating this agreement.
- ____ 15. If controlled medications are prescribed for me, I will be taking them to control my severe pain and improve my function; and I have not responded to other treatment.

Signature _____ Date _____ Witness initial _____



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