

COLLIER SPINE INSTITUTE
Controlled Substance Agreement

Controlled substance medications (i.e. narcotics, tranquilizers and barbiturates) are intended to relieve pain and improve function and/or ability to work. They are closely controlled by local, state and Federal Government. My physician may recommend such medication(s).

1. The goal of treatment is to help me gain control of my chronic pain in order to live a more productive and active life. The goal of taking narcotic(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. My progress will be periodically reviewed and, if the narcotics are not improving my quality of life, the narcotics will be discontinued.
2. Some persons may develop a tolerance and the need to increase the dosage of the medication. This must only be done after consultation with my physician. My dosage will be carefully monitored but it is still possible to become addicted to controlled substances. Some signs of addiction include increasing the dose on my own, seeing multiple prescribing physicians, running out of medication(s) early and getting extra medication(s) from friends and family. If I experience any of these signs or otherwise feel I am becoming addicted to my medication(s) it is my responsibility to promptly inform Collier Spine Institute ("CSI") so the appropriate treatment may be rendered. When I stop the medication(s), I need to do so slowly so as to avoid withdrawal symptoms.
3. These medications can have sedative effects. I understand that I must not use alcohol or illegal drugs while taking these medications. I should not use sleeping pills, cold medicines, or other medications that might cause drowsiness, dizziness or changes in thinking unless I first discuss them with CSI.
4. I understand that I should not drive, or operate heavy machinery if I feel tired, mentally foggy, or am experiencing other side effects from my medications. It is my responsibility to keep myself and others from harm.
5. Side effects and risks of long term use of narcotics may include, but not be limited to, constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention, insomnia, depression, impairment of reasoning and judgment, respiratory depression, impotence, tolerance to medication(s), physical and emotional dependence or even addiction and death.
6. For female patients only:
To the best of my knowledge, I am not pregnant at this time and I will use appropriate contraception during my treatment. If I become pregnant, I agree that I will inform CSI immediately.

In order to receive a prescription for controlled substances, I have agreed to the following conditions:

7. I will only use the pharmacy indicated below to fill my prescriptions. I authorize CSI to discuss my medical information with my pharmacist.

Pharmacy: _____ **Telephone Number:** _____

8. I hereby give CSI permission to communicate with referring physician(s), pharmacist(s), insurance companies or any other entity or person regarding my use of controlled substances.
9. I certify and agree to the following:
I am not currently abusing illicit or prescription drugs, and I am not undergoing treatment for substance dependence or abuse;

I have never been involved in the sale, illegal possession, diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

I am responsible for my medications: If the prescription or medication is lost, stolen, misplaced, or if I run out of the medication before time for a refill, I understand that it will **NOT** be replaced.

10. I will not request or accept controlled substance medications from any other physicians or individuals while I am receiving medication from CSI. I agree to inform any doctor who may be treating me for any medical problem that I am taking controlled substances. Besides being a violation of this Contract, taking additional controlled substances may endanger my health. If I do request or accept controlled substances from anyone else, I understand that CSI may refuse to prescribe controlled substances to me.
11. Refills of a controlled substance medication:
 - a. Will only be given during regular office hours, in person, during a scheduled office visit. They will not be made on weekends, holidays, or at night. Prescriptions will not be sent by mail, faxed, or filled by telephone request.
 - b. Will not be made if "I run out early." I am responsible for taking the medication as prescribed and keeping track of the amount remaining.
 - c. Will not be considered an "emergency". I will call at least 72 hours in advance.
12. I understand that this medication is for my personal consumption only. Giving or selling this medication to any other person(s) is a violation of this Contract, may result in serious injury or death to another person, and could subject me to civil or criminal prosecution.
13. I must take the controlled substance(s) exactly as instructed by CSI. Any unauthorized increase in the dose of narcotic medication(s) may be viewed as a cause for discontinuation of the treatment with controlled substance(s).
14. I agree to submit to urine and blood screens to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), or controlled substances not prescribed by CSI, treatment for chronic pain may be terminated.
15. I understand that if I violate any of the above conditions that my prescriptions will no longer be issued by this office.

I have been fully informed by CSI and/or its staff regarding the risks and side effects of controlled substances, including dependency (addiction) on controlled substances. CSI cannot guarantee that I will not become addicted to my medication(s). I freely agree to the use of the medication(s) and understand that no guarantees regarding safety or addiction are stated or implied. I have read the above information and it has been explained to me by Dr. Frank R. Collier Jr. and/or his staff. Any questions have been answered. I fully understand the consequences of violating said contract. I hereby authorize and give my voluntary consent to CSI to administer or prescribe the prescription(s), controlled substance(s), or narcotic medication(s) as an element in the treatment of my chronic, intractable pain.

Patient Signature

Date

Witness

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