**Narcotics Contract**

***Desert Foothills Concierge Medicine, LLC***

**Welcome!**

In order to commence your treatment for Chronic Pain Management you will first need to review, sign and return the associated Narcotics Use Contract. This contract exists between the patient and provider to ensure that there is a clear understanding of the expectations surrounding the provision and use of Narcotics for Chronic Pain Management.

Please print, sign and return this form via Email to: desertfoothillscm@yahoo.com

App Suggestion: TapScanner (free)

**Narcotics Contract**

***Desert Foothills Concierge Medicine, LLC***

Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The purpose of this contract is to define the expectations between the prescriber, Susan Uhrig CNP, 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. 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 provider.
3. I will not ask for early prescription refills except under the most adverse conditions.
4. No replacements will ve provided for lost medications or prescriptions.
5. If any 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 provider will need to see me for regularly scheduled visits every 30 days 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 medications refills at 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 provider 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 understand that the possible complications of chronic narcotic therapy include:

•Chemical Dependence

•Constipation, which could be severe enough to require medical treatment

•Difficulty with urination

•Drowsiness

•Nausea

•Itching

•Slowed respiration

•Reduced sexual function

•Withdrawal Symptoms may occur if medication is stopped suddenly

•Use of narcotics may impair my ability to operate a motor vehicle or heavy equipment

I have been informed that I may not take other drugs such as tranquilizers, sedatives of antihistamines without first consulting with my provider. I understand that I should not mix my medications with alcohol.

Failure to abide by these parameters will be grounds for termination of the prescription of narcotics by Susan Uhrig CNP as well as potential termination from this practice.

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

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**