Doctor/Patient/Clinic (Sample Medication Monitoring Agreement)

This agreement is between _____ (Patient) _____ (Doctor), and_____(Clinic). We at _____ understand that your pain is a significant hindrance to the quality of life you desire. In order to help you achieve your goals, we may recommend different medicines, selective diagnostic and therapeutic procedures, physical and occupational therapy, therapeutic massage, and psychological counseling, as needed. Narcotic Medication for pain may not be prescribed on first visit. This type of medication is solely given based on the medical findings and treatment plan of our doctor and not doctors you may have visited previously. Although narcotics have a long history of safety, there are possible side effects. Therefore, we must weigh the risks versus benefits before prescribing these medications. If we decide to use these medicines the following conditions must be met:

- I understand that a reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program.
- If deemed necessary, we may require a consult from a pain psychologist.
- Additional Therapy may be recommended for which you are required to participate.
- I realize that all narcotic medications have potential side effects. In addition to analgesia, narcotics may produce dependency, addiction, respirator depression, drowsiness, and changes in mood, anxiety, and mental clouding. I will report any such side effects to the physician immediately. Narcotics may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. I agree that I will not attempt to perform any such activity until my ability to perform the activity has been evaluated.
- I must maintain the dosing schedule prescribed by the doctors from this clinic. You may not increase the dose on your own. You must come in and discuss any changes before they are made. If you take your medication in any way other than prescribed, it may not be refilled.
- If you receive narcotics from any other clinic, doctor, or hospital, you are required to notify this clinic by telephone within one working day prior to filling the prescriptions.
- I must have your narcotic prescriptions filled at only one pharmacy and must have the pharmacy name and number on file at this office. Narcotics cannot be called in for any reason. Narcotic prescriptions can only be given to the patient. You may not sell, share or trade your prescriptions.
- Narcotic Prescriptions may not be replaced if lost, stolen, flushed, burned, or any other reason-even with a police report.
- I may be required to undergo random urine drug screen testing and random pill counts. If so, you will be contacted by telephone. It is your responsibility to provide a telephone number where you can be contacted during regular business hours _____. If you cannot answer your telephone personally, you are responsible for an answering machine or other method of receiving the telephoned message that day. If you fail to come in for a drug screen or pill count on the day you are called, you may not receive narcotic prescriptions from this clinic in the future.
- I must submit a urine Drug Screen at every office visit. These will be sent off to an independent lab for confirmation.
- In the event of a need to discontinue taking these medications, I will consult with the Doctor and strictly follow his/her instructions for the safe tapering off my medication. Failure to do so may result in severe withdrawal effects and possible even death. I understand that even with the tapering process there may be some discomfort or withdrawal effects.
- I must not take any illegal drugs or medications prescribed to someone other than you. You must avoid drinking alcohol if you are taking a narcotic medication for pain control. I understand I must contact my physician before taking sedatives, antihistamines, or benzodiazepines. Some examples include but are not limited to: Soma, Xanax, Ativan, and Benadryl.
- By signing this agreement you give this office permission to request information and share information about your narcotic prescription history with other pharmacies, medical offices or law enforcement agencies.
- I understand that all female patients should notify the physician if they are pregnant or possibly at risk to become pregnant. I understand that children born while the mother is on Opiate therapy would likely be physically dependent at birth.
- Should this office feel that I might be doing harm to another or myself, I agree to waive any applicable privilege or right to privacy or confidentiality with respect to the prescribing of my pain medication and/or mental state.
- If I am or ever have been on probation, or arrested for a narcotic-related offense, I understand I must disclose this information immediately.

This agreement is entered into on _____ (date).

My signature below acknowledges my understanding and agreement with the above stated terms.

Patient Name	Patient Signature
Doctor Signature	Witness Signature