CENTRAL WYOMING NEUROSURGERY
Medical Management Informed Consent for
Narcotic Analgesic Therapy

******Permission given by Tuenis D. Zondag, MD to use this document as a sample contract.***

Patient Name:_____ID#_____Date:_____

Primary Physician:_____Phone No:_____

CWNS Physician:_____Phone No:_____

Pharmacy:_____

This information and the following checklist are intended to help you understand that the management of your pain is your responsibility. Your primary care physician and the physicians and staff of Central Wyoming Neurosurgery will help you to meet your pain management needs by explaining to you:

1. Your current physical condition.
2. The proposed treatment.
3. The risks and advantages of the proposed treatment
4. The risks and advantages of alternatives.

You must also understand that you may be referred to others for additional management and/or treatment.

You must have a primary care physician to be eligible for pain management through our program. Pain management is only one aspect of your care. We require that your primary care physician not only agrees to your pain being treated by narcotics, but also is informed as to this aspect of your care. He/she will be continuously updated on your medications and health as it relates to your ongoing pain problems.

1[1]

To manage your pain effectively, narcotics will be prescribed for you. Narcotics such as Morphine, Fentanyl, and Oxycontin are the strongest known pain relievers. We need your cooperation and compliance for us to provide adequate pain and symptom control. It is crucial for you to schedule and attend regular appointments, as well as comply with the conditions stated on the following pages.

Patient agrees to the following terms as a condition of receiving care at Central Wyoming Neurosurgery for chronic opiate analgesic therapy.

_____

I agree to or represent the following:
Initial Here

_____1. I am ***not*** abusing illicit, non-prescription drugs.

_____2. I am ***not*** using alcohol.

_____3. I have never been involved in the sale, diversion or transport of controlled substances-such as: narcotics, sleeping pills, nerve pills, or pain pills.

_____4. I agree to take the narcotic analgesics ***only*** in dosage as prescribed by the physicians at **CENTRAL WYOMING NEUROSURGERY**.

_____5. I agree that the prescribed narcotic analgesics will be used only by ***myself.***

_____6. I understand that narcotic medications are potentially addictive and dangerous if not taken as directed.

_____7. I understand that the staff at **CENTRAL WYOMING NEUROSURGERY** may communicate with any pharmacy or healthcare official regarding my medications.

_____8. I understand that State law prohibits me from driving or operating dangerous equipment while taking any sedating medication, even if I don't feel sedated.

_____9. I understand that medications will ***ONLY*** be filled during regular business hours. Medications will ***NOT*** be filled for you over the weekend.

_____10. I understand that it is extremely dangerous to mix narcotic medication with tranquilizers such as: valium, xanax, klonopin, dalmane, ativan, restoril.

_____11. I agree that I will use only one pharmacy for filling of prescription narcotic analgesics.
If I desire to change pharmacies, I will inform CENTRAL WYOMING NEUROSURGERY so this agreement can be revised.

_____12. I agree to keep **CENTRAL WYOMING NEUROSURGERY** updated on all over-the-counter medications I take.

_____13. I understand that my narcotic prescriptions will be distributed monthly to the pharmacy I have designated to fill my prescriptions. I understand that the fill date listed on the prescription provides the amount of medication for a determined time frame.

_____14. I understand that if my pharmacy fills my prescription before the actual due date, or if I take additional medications there will be no additional meds to make up for my shortage.

_____15. I understand that if my current medications are ineffective, I will schedule an evaluation with **CENTRAL WYOMING NEUROSURGERY**. There will be no change in my medications until an evaluation is complete. I will bring with me to my appointment all of my pain medications.

_____16. I understand that appointments for medical evaluations are required at least every three months. I understand I must attend these appointments to continue a pain management affiliation with **CENTRAL WYOMING NEUROSURGERY.**

_____17. I understand it is my responsibility to keep my medications in a safety lock box and that no allowance will be made for lost or stolen prescription medications.

_____18. I understand that this agreement may be voided at any time by the physicians at **CENTRAL WYOMING NEUROSURGERY** if it is felt that this treatment is not of benefit to me socially, mentally, or physically, or I am in non-compliance with this contract.

_____19. I agree to have a urine or drug screen for medications done randomly at the request of **CENTRAL WYOMING NEUROSURGERY**.

_____20. I agree that if my narcotic medications are swallowed by anyone besides me, ***I will call 911 or Poison Control at 1-800-222-1222 immediately.***

_____21. ***(FEMALES ONLY)*** I certify that I am not pregnant at this time, and that if I become pregnant I will notify the physician at **CENTRAL WYOMING NEUROSURGERY** immediately and that my narcotic medications will be tapered and discontinued.

_____22. I understand that any of the following will result in tapering and discontinuing of narcotic pain therapy:

- Evidence of medication hoarding
- Increasing use of medication without communication with **CENTRAL WYOMING NEUROSURGERY** staff.
- Refilling my prescriptions too frequently
- Getting medication from multiple providers or pharmacies
- Increasing medication despite significant side effects
- Altering prescriptions
- Mediation sales
- Unapproved use of (***ALCOHOL, SEDATIVES, NON-PRESCRIPTION*** medications inconsistent with drug Labeling)
- Other unacceptable or illegal behaviors

_____23. I understand that appropriate authorities will be involved when there is evidence of illegal behavior.

_____24. I agree to review and abide by the policies of **CENTRAL WYOMING NEUROSURGERY.** These policies include office hours, phone numbers, procedures for making appointments, paying office fees and medication refill requests.

I have read this agreement and have had an opportunity to ask questions. All of my questions have been answered satisfactorily. I understand the risks, benefits, and side effects of narcotic medication. I consent to the use of narcotic analgesics under the terms outlined in this agreement.

I UNDERSTAND THAT IF I DO NOT COMPLY WITH THE ABOVE TERMS, MY MEDICATION WILL BE TAPERED AND/OR STOPPED.

Patient's Signature:_____Date:_____

Witness:_____Date:_____

Thank you,

Raedel

Source: Central Wyoming Neurosurgery group/Tuenis D. Zondag, MD.

The above pain management contract is only a sample. Health Care Providers are not required to use this particular contract. By providing this sample, we disclaim any and all liability that may result from its use.