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2023

CONTRACT FOR NARCOTIC/OPIOID MAINTENANCE THERAPY

1. I have suffered from a painful condition since: ____/_____/_____

2. **Principal diagnosis**:

3. I have attempted to relieve this condition with the following treatments without success:
   ☐ Surgery ☐ Physical Therapy ☐ TENS ☐ Biofeedback
   ☐ Implantable Device ☐ Relaxation Techniques ☐ Medications ☐ Steroid shots

4. I wish to use pain management (NARCOTIC/OPIOID MAINTENANCE THERAPY). This therapy may consist of chronic administration of narcotic/opioid medications for pain control. The principal narcotic/opioid medications are Morphine, Oxycodone, Hydrocodone, Hydromorphone, Methadone, and Codeine. These medications are controlled substances and are subject to a variety of legal constraints as to their prescription, use, and distribution.

5. I understand that narcotic/opioid medications may be prescribed alone or in combination, and they may be supplemented with other classes of medications, such as muscle relaxants, antiepileptic drugs, or antidepressants.

6. I understand that these narcotic/opioid medications are potentially dangerous medications and that, if taken improperly, may lead to excess sedation, respiratory depression, and death.

7. I understand that narcotic/opioid medications may cause a variety of side effects, including, but not limited to, *nausea, vomiting, constipation, dry mouth, fluid retention, weight gain, weight loss, suppression of the immune system, suppression of thyroid function, and suppression of menstrual cycle, suppression of male hormone, itching, and allergic reactions.*

8. I understand that narcotics/opioid medications are likely to induce **PHYSICAL DEPENDENCE**, and abrupt withdrawal is likely to cause symptoms such as *abdominal and muscle cramps, irritability, nausea, vomiting, sweats, chills, and generalized aching*. In some individuals, severe withdrawal reactions may be life threatening. I also understand that narcotics/opioid medications may be safely discontinued, when tapered slowly, and that even gradual discontinuation may lead to increased sensitivity to pain. I understand that if I am pregnant while taking narcotic/opioid medications, my child would be physically dependent on the opioids, and withdrawal can be life threatening for a baby. As such, I must immediately inform DR. Mc Pherson if I become pregnant prior to or during my pain management with narcotics/opioid medications.

9. I understand that I am likely to become **TOLERANT** to these medications, and as such I will most likely request increasing doses to achieve adequate pain relief.

10. I understand that chronic Narcotic/Opioid Maintenance Therapy is a controversial treatment and that there is significant disagreement regarding the use of these drugs for more than 6 months. I also understand that it is necessary for my pain management specialist to treat the medical conditions which are responsible for my chronic pain, and not simply focus on the symptom of pain.

11. I understand that PHYSICAL DEPENDENCE and TOLERANCE are different from ADDICTION, which refers to PSYCHOLOGICAL DEPENDENCE ON MEDICATION FOR PURPOSES OTHER THAN PAIN RELIEF.

Initial
Date:

12. **I agree to receive prescriptions for narcotic/opioid medications ONLY FROM DR. MCPHERSON, while I remain under his care, and to inform other treating physicians, regarding the medications I receive for pain management.**

13. **I understand that IT IS ILLEGAL TO give CONTROLLED SUBSTANCES, PRESCRIBED FOR MY USE, TO ANOTHER PERSON, and I agree to take strict precautions to prevent unauthorized access to my narcotic/opioid medications.**

14. **I understand that narcotic/opioid medications may impair alertness, coordination, and that IT IS ILLEGAL TO OPERATE A MOTOR VEHICLE WHEN THE ABILITY TO DRIVE IS IMPAIRED BY THESE MEDICATIONS, and I agree to comply with these restrictions.**

15. **I understand that the effects of sedatives, muscle relaxants, and mind-altering medications or other chemicals may be dangerously increased when administered to a patient on narcotic/opioid medications. I agree to inform other physicians as to which medications I am taking and to request that they consult with Dr. McPherson regarding the co-administration of medications that may affect alertness or consciousness.**

16. **I will control my usage of narcotic/opioid medications as directed by Dr. McPherson. THERE ARE NO EXCEPTIONS. If the medication is inadequate in controlling my pain, I must call Dr. McPherson. The dosage of narcotic/opioid medications cannot be changed by anyone.**

17. **I agree to follow Dr. McPherson's orders, which may include participation in pain-management instruction classes, psychological counseling, exercise, physical therapy, etc.**

18. **Typically, my prescriptions for the number of narcotic/opioid medications will be electronically sent to my pharmacy. I understand that I am responsible for my medication. NARCOTIC/OPIOID MEDICATION THAT IS LOST, STOLEN, OR MISPLACED FOR ANY REASON WILL NOT BE REPLACED.**

19. **I will manage my medication to prevent shortage prior to my scheduled appointment with Dr. McPherson. REPEATED PHONE CALLS TO OBTAIN ADDITIONAL MEDICATION WILL NOT BE TOLERATED AND WILL RESULT IN MY DISCHARGE FROM SELSON CLINICS NEUROLOGY.**

20 **I agree to ADHERE STRICTLY TO MEDICAL INSTRUCTIONS AND LAWS governing the use of these medications and TO REFRAIN FROM THE USE OF ILLEGAL DRUGS, MARIJUANA OR ALCOHOL while on narcotic/opioid medications. I authorize Dr. McPherson to randomly test my blood or urine for the presence of illegal substances.**

21. **I understand that Dr. McPherson and Selson Clinics Neurology are subject to monitoring by regulatory medical and pharmacy authorities. I waive any privilege of confidentiality regarding records of my medical care and authorize Dr. McPherson to release copies of my medical records to such authorities.**

22. **My signature below, signifies that I have read each article in this document, and agree to abide by its requirements. I understand that FAILURE TO DO SO WILL LEAD TO TERMINATION OF THIS TREATMENT.**

_____

Patient's Signature:
Date:

Physician Certification

I fully discussed the above document with the patient whose signature appears above. I believe that this patient suffers from the condition indicated above, that this condition causes pain, and that this patient is a candidate for pain management with narcotic/opioid medications.

Patient's Signature: **Selwyn-Lloyd Mc Pherson MD**
Patient's Printed Name: **Date:**
Date: