OCH

Sports Medicine and Orthopedic Center

OPIOID PRESCRIPTION AGREEMENT

OCH Orthopedic Center | 401 Hospital Drive Starkville, MS 39759 | Phone: 662-615-3691 Fax: 662-615-3698

1. I understand that I am being given a prescription for opioid pain medications, which are controlled substance monitored by the drug enforcement agency. (DEA)
2. I agree to take these medications exactly as prescribed by my physician. I will not take this medication more or in larger amounts than instructed. I understand that doing so will result in me no longer receiving opioid medications for my pain.
3. I will not share, sell or trade these medications, as this is illegal and punishable under state and federal law. I will not crush, chew or alter medications in any way
4. I understand that it is my responsibility to safeguard my mediations from theft and they will not be replaced if lost or stolen.
5. I understand that as part of my treatment plan, a random blood or urine sample may be required for drug testing purposes. Failure to provide a blood or urine sample will result in me no longer receiving opioid medications for my pain. If any illegal substance is found in my urine or blood test I will no longer receive opioid pain medications.
6. I understand that as part of my treatment plan, all prescriptions that I receive from this physician will be reviewed periodically.
7. I understand that I am only to obtain opioid pain medications including Morphine, hydrocodone, Lortab, Lorcet, Norco, Vicodin, Oxycotin, Oxycodone, Methadone, Hydromorphone, Dilaudid, Exalga, Oxymorphone, Opana, Exalgo, Nucynta, Duragesic, or Fentanyl Patch, Fentanyl, Meperidine, and Demerol, from one physician. If I obtain these medications from another provider, I am to notify OCH Orthopedic Center at 662-615-3741 within 24 hours if receiving medications. Failure to do so will result in me no longer receiving my opioid medication.
8. I understand that a partial reduction in my pain and improvement of quality of life and functional status are the goals of opioid therapy. If there is no improvement in quality of life or increased activity, these medications may not be continued.
9. Side effects may include drowsiness, constipation, abdominal pain, slowed breathing, liver damage, nausea, itching, depression, increased pain, and decreased sex hormones. There is a risk of addiction and physical dependency with opioid medications. If they are abruptly stopped, you may experience withdrawal symptoms including sweating, nervousness, diarrhea, and abdominal pain.
10. I understand I should avoid alcohol while taking opioid medications. They may also increase my risk of falls or impair my ability to drive a car or operate heavy machinery.
11. OCH Orthopedic Center has established a protocol for refills of controlled substances. The physician, physician's assistant, and nurse follow this protocol in determining the medication to be refilled. Adjustments in the medication (both strength and brand) will be made according to the protocol.
12. Refills of controlled substance medication:

- Refills will only be made the same day if you are here for an appointment.
- Refills require a 72 hour notice to allow providers sufficient time to pull and research my chart for prescription refills. Refills will not be filled Fridays, nights, holidays or weekends.
- If the prescription is to be mailed, I will supply the office with a self-addressed stamped envelope.
- If picking up the prescriptions, I may do so during regular office hours.
- Refills will not be made if I "run out early."

I have been fully informed by OCH Orthopedic Center regarding dependence versus addiction to a controlled substance. I understand that some persons may develop a tolerance which is the need to increase the dose of medication to achieve the same effect of pain control and I am also aware that I may become physically dependent on the medication. This will occur if I am on the medication for extended periods of time. When I stop the medication I will do so slowly and under medical supervision or I may have withdrawal symptoms. I understand, if after 3 months, my pain is not under control, I will be referred out to a Pain Management Clinic.

I have read this agreement and it has been explained to me. In addition, I fully understand the consequences of violation of said contract.

Print Name_____Sign Name _____Date/Time_____

Date of Birth: _____