ARTHRITIS & RHEUMATOLOGY
CENTER OF SOUTH FLORIDA

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Narcotic Agreement

Narcotic agreement is being executed today to prevent misunderstandings about opioid analgesics I will be taking for pain management. This is to help me and my healthcare provider comply with the law regarding controlled pharmaceuticals. The goal of my treatment is to reduce pain to a level that is tolerable and allow me to improve day-to-day functioning. I understand that there are alternative treatments available including non-narcotic analgesics, physical therapy modalities including neuromuscular reeducation, psychological intervention, invasive procedures including injections and surgery.

I understand that narcotic medication may cause side effects including but not limited to nausea, vomiting, constipation, dry mouth, fluid retention, weight gain, weight loss, hormone suppression, itching, allergic reaction and if taking improperly may lead to excessive sedation, respiratory depression and death.

I understand that intolerance may develop and higher dose may be required to achieve adequate pain relief I understand that narcotics are likely to induce physical dependence and that abrupt withdrawal is likely to cause withdrawal symptoms. I understand that physical dependence and tolerance are different from addiction, which refer to psychological dependence on medication for purposes other than pain relief.

By signing I agree that Arthritis & Rheumatology Center of South Florida will be the sole provider of narcotic medication and I will not exceed prescribed dose. I understand that using my medicine at a rate greater then prescribed will result in my being without medication for a period of time. Lost prescriptions or medications including those stolen or inaccessible will not be replaced.

I agree to refrain from the use of illegal drugs and excessive alcohol. Noncompliance with the agreement may be grounds for discharge from the medical practice. Monthly visits will be required for medications that are not refillable.

No refills will be available during evening or weekend hours.

I agree to use only one pharmacy for filling narcotic prescriptions. The name, address and telephone number will be given to the office.

Patients may be subject to random urine or blood monitoring.

I certify that I've never been involved in the sale, illegal possession, diversion nor transport of controlled substances.

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I authorize the physician and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this states Board of Pharmacy, in any investigation of any possible misuse, sale or other diversion of my pain medicine. I authorize my physician to provide a copy of this agreement to my pharmacy. I agree to allow the physician to communicate with other physicians and any pharmacists regarding use of controlled substances.

My signature below signifies that I've read each article in this document and my questions and concerns regarding treatment have been answered. I agree to abide by its requirements.

Signature:_____
Date:_____

Physician's Certification:

I have reviewed the above document with the patient whose signature appears above. I believe that this patient suffers from chronic pain and that this patient is a candidate for pain management with opioid analgesics. This patient agrees that Arthritis & Rheumatology Center of South Florida will be the sole prescriber of narcotic medications and will not exceed prescribed doses. Noncompliance with this contract may be grounds for discharge from the medical practice.

Physician signature:_____

Date:_____