

# Pars Interventional Pain & Wellness Center

1212 Garfield Avenue, Suite 202

Parkersburg, WV 26101

304-865-7277

304-865-7273 (fax)

## Consent & Agreement for the use of Controlled Substances, including Opioids For the Treatment of Chronic Pain

I, \_\_\_\_\_ (the patient) have been given a prescription for a controlled substance medication, which may include opioid medicine, also called narcotic pain medication by the physicians at Pars Interventional Pain & Wellness Center. This decision has been made because my condition is serious or other treatments have not helped my pain. The medication was chosen to treat my pain in order for me to experience an improvement in my quality of life.

1. I understand that these substances are strong medications for the relief of my discomfort and I am aware that the use of such medication has certain risks or side effects.
2. In particular, I understand that opioid analgesics could cause physical and/or psychological dependence. When I stop the medication, I must do so slowly and under medical supervision. If I suddenly stop or decrease the medication, I could experience withdrawal symptoms (flu-like symptoms such as nausea, vomiting, diarrhea, aches, sweats, and chills) that may occur within 24-48 hours after the last dose. I understand that opioid withdrawal is quite uncomfortable, but not a life-threatening condition.
3. Other possible side effects may include constipation, nausea, itching, vomiting, dizziness, and allergic reaction.
4. I understand that it is my responsibility to inform the doctor of any and all side effects I may have from this medication.
5. Overdose of this medication may cause death because my breathing could stop. Emergency medical personnel can reverse this if they know I have taken narcotic pain medicine. It is suggested that I wear a medical alert bracelet or necklace that contains this information.
6. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.
7. I agree to take this medication as prescribed, and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. Running out of the medication early, needing early refills, increasing doses without permission, and losing prescriptions may be signs of misuse of the medication, and may be reasons for the doctor to discontinue prescribing it to me.
8. I agree that only **one doctor** will prescribe all controlled substances and/or narcotic pain medications and I agree to fill my prescriptions at only **one pharmacy**. I agree not to take any other controlled substances – narcotic medications or mind altering medication prescribed by any other physician without first discussing it with a Pars Interventional Pain & Wellness physician(s). I give permission for the doctor(s) to verify that I am not seeing other doctors for controlled substances – narcotic medications or going to other pharmacies.
9. I understand that it is my responsibility to inform the Emergency Room (ER), Med-Express, Quick-Care, etc. physician that I'm under a drug contract with Pars Interventional Pain & Wellness Center and inform the physician what medications we are prescribing. I also understand that I'm to inform the Pars Interventional Pain & Wellness Center within 24 hours that I've been to the ER, Med-Express, Quick-Care, etc. If on a weekend please call first thing Monday morning. Call and leave a message on the Nurse's Line 304-865-7277 option 3.
10. I am responsible for my controlled substance – opioid medications. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication **will not** be replaced.
11. If being prescribed Duragesic (Fentanyl) patches and a patch comes off then, I'm to notify Pars Interventional Pain & Wellness Center. I'm to save the patch and bring it into the office to be disposed of.
12. I agree to read all handouts and literature that comes with my medications and to follow all instructions printed or attached to my medication.
13. I agree not to sell, lend, or in any way give my medications to any other person(s).

**Consent & Agreement for the use of Controlled Substances, including Opioids  
For the Treatment of Chronic Pain (continued)**

14. I agree not to drink alcohol or take other mood-altering drugs while I am taking controlled substance/opioid medications. I agree to provide a blood and/or urine sample at any time my doctor requests it in order to be tested for the presence of alcohol or any and all drugs.
15. I agree to attend all required follow-up visits with the doctor to monitor this medication. I also agree to attend and participate in all other therapy or treatment recommended by my doctor. I understand that failure to do so may result in the discontinuation of this and all other treatment(s) by my doctor.
16. I understand that there is a small risk that opioid addiction could occur. If I become psychologically dependent on the medication, if I use it to change my mood or to get high, if I become unable to control my use of my medication, if I take it in any way other than instructed, or for any purpose other than that indicated by my doctor, I will inform my doctor immediately. I agree to inform my doctor even if I feel tempted to abuse my medication in any way.
17. People with a past history of alcohol or drug abuse problems are more susceptible to addiction or abuse of controlled substances. I agree to inform my doctor of any history of prescription, illegal drug abuse or alcohol abuse/addiction, and that of my family members.
18. **(Males Only)** I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.
19. **(Females Only)** If I plan to become pregnant or believe that I have become pregnant while taking controlled substance – opioid medication, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to term while taking these medicines; the baby will be physically dependent upon these medications. I am aware that the use of controlled substance – opioid medications is not generally associated with the risk of birth defects.
20. I understand that if I violate any of the above conditions, my controlled substance prescriptions and/or treatment may be ended immediately. If the violation involves obtaining controlled substances from another individual, I may also be reported to my other physicians, medical facilities (emergency rooms), and local authorities.
21. I hereby consent or agree to sign any and all documents requested by Pars Interventional Pain & Wellness Center for the purpose of enforcing the terms and conditions of this consent.

**I have read this form or have had it read to me. I understand all of it. I have had a chance to have all my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with controlled substance/opioid medications.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Location \_\_\_\_\_

Pharmacy Phone \_\_\_\_\_ Pharmacy Fax \_\_\_\_\_

---

I, \_\_\_\_\_ (patient name) have received a copy of the drug contract that was explained to me on \_\_\_\_\_ (date) by \_\_\_\_\_ (employee).

Patient Signature \_\_\_\_\_ Witness \_\_\_\_\_

---

**Reviewed on:**

Date \_\_\_\_\_ Patient Signature \_\_\_\_\_ Witness \_\_\_\_\_

Date \_\_\_\_\_ Patient Signature \_\_\_\_\_ Witness \_\_\_\_\_

Date \_\_\_\_\_ Patient Signature \_\_\_\_\_ Witness \_\_\_\_\_

Date \_\_\_\_\_ Patient Signature \_\_\_\_\_ Witness \_\_\_\_\_

# Pars Interventional Pain & Wellness Center

1212 Garfield Avenue, Suite 202

Parkersburg, WV 26101

304-865-7277

304-865-7273 (fax)

## **Contract for Controlled Substances:**

The following is a contractual agreement for controlled substances to be used in conjunction with ongoing medical care and chronic pain management on behalf of

\_\_\_\_\_ (patient) residing at \_\_\_\_\_ in the city of \_\_\_\_\_, state of \_\_\_\_\_ as a binding contract with Pars Interventional Pain & Wellness Center.

I, \_\_\_\_\_ (patient) do hereby declare and affirm that I will not seek narcotic, opiate or any other controlled substance medications from any other doctor other than Pars Interventional Pain & Wellness Center. I understand that if I am found to have obtained such medications from another doctor, without express written permission from Pars Interventional Pain & Wellness Center. I further understand that civil and criminal action may be pursued by Pars Interventional Pain & Wellness Center, dependent upon the circumstances of the violation of this contract. I hereby also release Pars Interventional Pain & Wellness Center from doctor-patient restrictive covenants in so far as allowing them to discuss or validate my compliance with the terms of this contract.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Parent or Guardian of Minor)

\_\_\_\_\_  
(Witness)