BPM Beresh Pain Management

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AGREEMENT FOR PRESCRIBING OF NARCOTICS FOR CHRONIC PAIN

The following agreement between **Dr. John E. Beresh** and the patient, _____, outlines the duties and expectations of each party unless written notice is given by either party to cancel or amend said agreement. The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician/health care provider comply with all state and federal regulations concerning the prescribing of controlled substances. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

_____. Hereafter, referred to as patient and **Dr. Beresh,** hereafter, referred to as Doctor; agree that the patient suffers from chronic pain which has not been relieved by other pain control methods and deserves a trail, and possibly long term use of narcotics/opiate medications. The doctor agrees to provide prescriptions for the patient in a medically appropriate manner according to his/her judgment and training as well as what is considered usual and customary practice for the specialty of pain management. The goal of narcotic analgesic use is not only to decrease pain but also to improve function. The level of function will vary individually. It may be expected for the patient to participate in a functional restoration program including physical and psychological care as prescribed by the doctor. If the patient makes no effort to improve function, the medication may be discontinued.

I have agreed to use opioids (morphine-like drugs) as part of my treatment for chronic pain. I understand that these drugs can be very useful, but hide a high potential for misuse and are therefore closely controlled by local, state, and federal government. Because my physician is prescribing such medication to help with my pain, I agree to the following conditions:

1. I am responsible for my pain medications. I agree to take the medication only as prescribed.
   a. I understand that increasing my dose without approval and/or close supervision of my physician could lead to drug overdose causing severe sedation and respiratory depression and death.
   b. I understand that decreasing or stopping my medication without close supervision of my physician can lead to withdrawal. Withdrawal symptoms can include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, abdominal cramps, and diarrhea. These symptoms can occur 24-48 hrs after the last dose and can last up to 3 weeks.

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2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician at this pain center.
3. There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing) and may lead to death. It is my responsibility to notify my physician of any side effects that continue or are severe (i.e. sedation, confusion). I am also responsible for notifying my pain physician immediately if I need to visit anther physician or need to visit an emergency room due to pain, or if I become pregnant.
4. I understand that the opioid medication is strictly for my own use. The opioid should never be given or sold to others because it may endanger that person's health and is against the law.
5. I should inform my physician of all medications I am taking, including herbal remedies. Medications like Valium or Ativan; sedatives such as Soma, Xanax, Fiorinal; antihistamines like Benadryl; herbal remedies, alcohol, and cough syrup containing alcohol, codeine, or hydrocodone can interact with opioids and produce serious side effects.
6. I understand that opioid prescriptions will not be mailed. It is my responsibility to keep my scheduled appointments so that I do not run out of medication.
7. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.
8. I will communicate fully with my physician to the best of my ability t the initial and all follow-up visits my pain level and functional activity along with side effects of the medications. This information allows my physician to adjust my treatment plan accordingly.
9. I will not use any illicit substances, such as cocaine, marijuana, amphetamines, etc. while taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship.
10. The use of alcohol with opioid medications is contraindicated.
11. I will utilize only one pharmacy to obtain the medications.
    Pharmacy_____ Phone: _____
12. I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen, I will obtain a report from the local police department. If my medications are lost, stolen, or misplaced my physician may choose not to replace the medications or to taper or discontinue the medications.

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13. Prescriptions for any medications will be done only during an office visit or during regular office hours. No refills will be done on evenings or weekends. Refills will not be made as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow".
14. To see a psychologist or psychiatrist as directed by the above-mentioned doctor if so requested and follow up is indicated. I Also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program to secure increased function and improve coping with my condition.
15. To notify the pain management physician of any change in my medical condition even if being treated by another physician.
16. I will not hold the physician or any member of Beresh Pain Management, Inc. liable for problems caused by the discontinuance of the controlled substances, provided that I received 30-days notice of termination.
17. I agree to submit to random urine, blood and or mouth swab screens to detect the use of non-prescribed medication or illicit drugs at anytime, possibly at my own expense.
18. I agree to come in on short notice for random pill counts to help assure the medication is not being diverted.
19. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.
20. The patient understands that chronic narcotic use may result in several problems including:
    a. TOLERANCE – the need to increase medication dosage to maintain relief, and it is possible that eventually there may be a need to discontinue the medication due to failure to obtain relief at dosages without side effects.
    b. PHYSICAL DEPENDENCE – this means the body undergoes changes when exposed to long-term narcotics/opiate use, which may result in a withdrawal syndrome if abruptly discontinued.
    c. ADDICTION – this term does not apply to the patient simply taking these medications regularly for pain relief. However, it is possible to start taking them only for psychological affects (such as euphoria) and taking them in a compulsive manner to the detriment of the patient's well-being, i.e., addiction is a behavior and this potential behavior will be monitored by the prescribing physician.
    d. OVERDOSE – these medications can cause severe sedation and possibly death from depression of breathing, circulatory failure, or fluid in the lungs.
    e. COMMON SIDE EFFECTS – nausea, impotence, difficulty urinating, confusion, constipation, decreased libido, sedation, swelling, sweating, weight gain, and itching.
    f. LOSS OF MEDICATION FROM THEFT – it is possible due to the "street value" of these medications to certain individuals. Medications will be refilled only at the discretion of the prescribing physician. Also, a repot should be filed with the insurance company and/or police department.
    g. LOSS OF MEDICATIONS BY LOSS, DAMAGE, OR CONTAMINATION – repetitive losses may be construed as non-acceptable behavior and result in cessation or discontinuance of medication.

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h. LACK OF ANALGESIC – some pain is not relieved by opiates and the patient may continue to experience pain regardless of the amount of drug taken. If this occurs, the doctor will wean and discontinue the medication and use another form of therapy.

i. WITHDRAWAL – nausea, diarrhea, sweats, chills, irregular respirations and/or heart rate can occur when a sudden decrease or elimination of opiates occurs.

Please Note: Narcotic/opiate medications may cause drowsiness and sedation in some patients. It is recommended that people taking these medications not operate a motor vehicle or machinery. Also, there may be an increase risk of injury in certain occupations that involve use of machinery or other tools. This should be discussed on an individual basis with your doctor.

NOTE:

- The doctor will not fill a prescription more than three days prior to its due date.
- If the medications are taken in a manner other than prescribed, the doctor reserves the right to refuse to refill the prescription.
- Failure to comply with the above may result in immediate discharge from this practice.
- Medications will not be filled after hours, on weekends, or on holidays. It is the responsibility of the patient to keep up with their medications and the amount remaining. The office should be notified 72- hours in advance before a refill is due if the patient is not scheduled for an office visit prior to window. Calls for refills can be made on Monday through Friday, 8:00 a.m. to 4:00 p.m. at 513-737-7246.

By signing this form you affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

_____	_____
PATIENT	DATE
_____	_____
PHYSICIAN	DATE
_____	_____
WITNESS	DATE

_____ Initials