

Intermountain Neurology, Skyline Pain Clinic, Hormone Specialists Clinic

Jahan Imani, MD Danna Schow, FNP-C Jared Abrams, PA Marinda Paskett, ANP-C

AGREEMENT FOR LONG-TERM CONTROLLED SUBSTANCES AND CHRONIC PAIN MANAGEMENT

The purpose of this agreement is to ensure that our clinic is in compliance with State and Federal guidelines and that we are prescribing drugs in the most safe and appropriate way. Our intention is to protect our ability to prescribe for you within legal guidelines.

The long term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long term benefit. There is also the risk of addictive disorder developing or relapsing occurring in a person with prior addiction. The extent of this risk is not certain. These drugs have potential for abuse or diversion. Strict accountability is necessary when use is prolonged. For this reason, the following are policies which are in place and must be agreed to be seen as a patient by our clinic.

- 1. As a patient, you are expected to treat our staff with respect at all times.** Any verbally abusive language, threatening, sexually inappropriate comments or other behavior will not be tolerated under any condition. Such behavior can result in termination of your pain clinic agreement and services.
- 2. It is understood that any medical treatment is initially by trial, and that continued prescription changes are contingent on evidence of benefit.** Continuing therapy (specifically including all opiates and/or narcotic pain medications) will be at the provider's discretion and will be based upon evidence of benefit, patient adherence to therapy and associated risk of therapy to the patient.
- 3. All controlled substances used for pain relief must come from providers within Skyline Pain Clinic unless specific authorization is obtained for an exception.** As a patient, you must agree that all pain medications are to be managed and prescribed by this clinic only. This is to prevent the phenomenon known as "Dr. Shopping" as well as to provide better overall care through prevention of medication interactions and over prescribing, poor coordination of treatment and risk of abusing these medications which can put you at risk for overdose.
- 4. All controlled substances must be obtained at the same pharmacy.** You cannot fill your prescriptions at more than one pharmacy and when switching pharmacies you must inform Skyline Pain Clinic of the change. Filling at one pharmacy is for your safety and to allow the pharmacist to review an accurate list of all of your prescriptions in order to ensure your safety and a minimum of medication interactions.
- 5. Unscheduled or randomly selected urine or toxicology screenings will be performed in addition to regularly scheduled testing.** This is done to deter medication abuse or divergence from our clinic. If you are consistently unable to come in for this random UA within the time frame given, or we are consistently unable to reach you for this, you will be held in violation of your agreement. Presence of unauthorized or illicit substances will be grounds for probation and/or termination of your pain clinic agreement.
- 6. You are expected to inform our office of any new medications or medical conditions and of any adverse effects you experience from any of the pain medications that you take from our clinic.**
- 7. The prescribing healthcare provider has permission to discuss all diagnostic and treatment details with dispensing pharmacists, or other professionals who provide for your healthcare.** This helps maintain accountability and continuity of care among your providers.

5315 South Adams Ave Pkwy, Suite A & B Washington Terrace, UT 84405

&

722 W Shepard Lane, Suite 102 Farmington, UT 84025

Phone: 801.475.7707 or 801.476.4448

Fax: 801.475.7322 or 801.476.4449

Intermountain Neurology, Skyline Pain Clinic, Hormone Specialists Clinic

Jahan Imani, MD Danna Schow, FNP-C Jared Abrams, PA Marinda Paskett, ANP-C

8. **You may not share, sell or otherwise permit others to have access to these medications.** Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safe guarded. It is expected that you take the highest possible degree of care with your medications and prescriptions. It is a felony to share your medications or take medications from a family member or friend.
9. **Many of the medications prescribed by our office can be hazardous or lethal to animals and people who have not taken the medications.** This is true with children and the elderly. You must keep them out of reach. It is highly recommended that you purchase a lock box or safe to prevent access to your medications by anyone but yourself.
10. **It is highly recommended that you do not drive for two weeks after starting therapy or a change is made in your narcotic pain medications.** This is for your safety and the safety of those around you.
11. **Medications WILL NOT BE REPLACED if they are lost, get wet, destroyed, stolen, etc.** If your medications are lost, stolen, ruined or otherwise rendered unusable, you will NOT be given another prescription under any condition. Your provider may prescribe medication to help with withdrawal symptoms.
12. **It is understood by the patient that stopping these medications can cause withdrawal symptoms and potential serious complications.**
13. **Original containers of medications are required to be brought at each office visit.** Expect that your medications will be counted at each visit to ensure the medications are being used according to the regimen prescribed by your provider. Failure to bring in your medications with each visit or evidence of overusing your medications can result in being placed on probation and/or termination of your pain clinic agreement and services.
14. **Early refills are not given.** The provider may choose to make an exception to this under certain circumstances, however, expect that you will not receive early refills.
15. **Please plan for prescriptions to be filled Monday through Thursday.** We will not be available to fill or refill your medications Friday through Sunday.
16. **Renewals are contingent on keeping scheduled appointments.** Concerns, questions and issues should be discussed during your scheduled appointment. If an issue does arise outside of your scheduled appointment and you call our office, please keep in mind that our providers are giving other patients the same level of care that is given to you and they will address your issue as soon as they are able. **Please do not call our office for prescription refills. You need to call your pharmacy.**
17. **Confidentiality Waiver.** If any government organization such as any police jurisdiction or the DEA have any concerns, questions or investigation concerning your treatment, as might occur if you obtain medications at more than one pharmacy or through more than one provider, all confidentiality is waived and these authorities will be given **full** access to your records.
18. **It is understood that failure to adhere to any of these policies may result in termination of your agreement with Skyline Pain Clinic.**
19. **The risks and benefits of these therapies have been explained to you and any questions answered.**
20. **You affirm that you have full right and power to sign and are bound by this agreement and that you have read, understand and accept all of terms within.**

5315 South Adams Ave Pkwy, Suite A & B Washington Terrace, UT 84405

&

722 W Shepard Lane, Suite 102 Farmington, UT 84025

Phone: 801.475.7707 or 801.476.4448

Fax: 801.475.7322 or 801.476.4449

Intermountain Neurology, Skyline Pain Clinic, Hormone Specialists Clinic

Jahan Imani, MD Danna Schow, FNP-C Jared Abrams, PA Marinda Paskett, ANP-C

CONSENT for CHRONIC OPIOID THERAPY: A consent from the American Academy of Pain Medicine

Our healthcare providers may prescribe opioid medicine, sometimes called narcotic analgesics. This decision was made because other treatments may not have helped my pain. I am aware that the chronic use of medication has certain risks associated with it including but not limited to; drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reactions, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, loss of bone density, the possibility that medications will not provide complete relief, and in rare cases death. I am aware of possible risks and benefits of other types of treatments that do not involve the use of opioids such as physical therapy, psychological therapy, and injection therapy. I will tell my healthcare provider about all other medications and treatments I am receiving. I will not be involved in any activity that may be dangerous to me or someone else if I fell drowsy or if I am not thinking clearly. Such activities also include driving, operating heavy machinery, climbing, or caring for other individuals. I am aware that even if I do not notice it, my reflex reaction time may be slowed which puts me at increased risk of automobile or other accidents.

I am aware that certain other medications such as Nalbuphine, Pentazocine, Buprenorphine, Butorphanol and other medications may reverse the action of the medications I am taking for pain control. Taking any of these medications while I am taking my pain medication(s) can cause symptoms leading to withdrawal syndrome. I agree not to take any of these medications and to tell any other healthcare providers that I am taking my opioids as my pain medication.

I am aware that **ADDICTION** is defined as the use of medications even if it causes harm, having cravings for a drug, feeling the need to use a drug and decrease quality of life. I am aware that the chance of becoming addicted to my pain medication is possible. This risk is much higher in individuals with a history of drug or alcohol addiction. I agree to tell my healthcare provider my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand the **PHYSICAL DEPENDENCE** is an expected result of using these medications for long periods. I understand that physical dependence is not the same addiction. I am aware that physical dependence means that if my pain medication use is markedly decreased stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that **TOLERANCE** to analgesia means that I may require more medication to get the same amount of pain relief. I am aware that tolerance to analgesia occurs with patients with chronic pain. If it occurs, increasing my doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my healthcare provider to choose another form of treatment. Additionally, I realize that long term opiate medications use may lead to increased difficulty in pain management while hospitalized for other conditions.

(Males Only) I am aware that chronic opioids use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire, physical and sexual performance. I understand that my healthcare provider may check my blood to see if my testosterone level is normal.

(Females Only) If I plan to become pregnant or believe that I may have become pregnant while taking this pain medication, I will immediately contact my obstetric doctor and this office to inform them. If I am child bearing age, I understand that I should discuss contraception with my primary care provider or OB/GYN. I am aware that should I carry a baby to delivery while taking these medications, the baby will be physically dependent upon opioids upon birth. Opiate dependent babies have been shown to have increased risk of being admitted to the Newborn Intensive Care Unit among other potential complications. Birth defects can occur whether or not the mother is on medications and there is a possibility that my child will have a birth defect while I am taking opioids.

I have read this and understand all of it. I have had a chance to have all my questions regarding this treatment answered to my satisfaction. By signing below, I give consent for treatment of my pain with opioid/other pain medication.

Patient Name: _____ Date of Birth: _____

Pharmacy: _____ Date: _____

Patient Signature: _____

3515 South Adams Ave Pkwy, Suite A & B Washington Terrace, UT 84405

&

722 W Shepard Lane, Suite 102 Farmington, UT 84025

Phone: 801.475.7707 or 801.476.4448

Fax: 801.475.7322 or 801.476.4449