MGH PAIN MANAGEMENT CENTER
CONTROLLED MEDICATION AGREEMENT

I ____agree to participate in a program of pain management with the physicians of the MGH Pain Center. I may be provided with controlled medications such as opioids, for the treatment of ____________________ pain only while actively participating in the program, if I adhere to the following regulations:

1. **Risks:** I understand that some risks associated with long-tem controlled medications are dependence, addiction, tolerance, constipation, sleep changes, potential for increased pain, risk to unborn children, changes in appetite, coordination, sexual desire and sexual performance. Stopping such medications suddenly can cause withdrawal. Combination with other drugs (including alcohol and nicotine) can lead to breathing and other problems. I will notify my Pain Physician if I experience any of these conditions.
2. **Treatment Plan:** I agree to adhere to the treatment plan the physician discussed with me regarding controlled medication including; type of drug, method of drug delivery, frequency, and dosage.
3. **Prescription Source:** I will receive controlled substances for the treatment of pain only from the PAIN MANAGEMENT CENTER. Should a new or worsening condition be diagnosed and controlled medicaton is provided by a physician outside the Pain Center, I will notify the Pain Center of this as soon as possible.
4. **Pharmacy:** I will use only one pharmacy ___________________ #_______________________for controlled medication prescriptions. If I need to change my pharmacy, I will notify the Pain Center.
5. **Safety of Medications:** I understand that I am solely responsible for the safe keeping of my medication. In the event that it is lost, stolen, destroyed or used other that than prescribed, the Pain Center **will not** replace the prescription until the due date of my next refill. To aid with the signs and symptoms that I may experience due to withdrawal, a prescription of clonidine may be called in to my local Pharmacy. I will be required to provide a police report on or before my next scheduled appointment.
6. **Discontinued Therapy:** Controlled medication may be discontinued if the fails to achieve set goals. I agree to participate in a drug detoxification program if prescribed. Discharge from the Pain Center will occur if I obtain multiple controlled medication from multiple practitioners, fill prescription at multiple pharmacies, sell or give away or otherwise divert the medication from its intended use, or alter prescriptions. Patients that miss three (3) consecutive appointments (cancellation or no show) will be discharged to the care of their Primary Care Physician.
7. **Testing:** I understand that my urine and/or blood my be tested at any time for levels of the substances in my system. I may be requested to bring in my medication for the physician to inspect.
8. **Appointments:** If I am on stable doses of controlled medication, I still need to schedule and keep appointments with my Pain physician to assure that I do not run out of my medications.
9. **Consent:** I give my consent for the physician and staff to speak with my pharmacist and other physicians to exchange pertinent information regarding my medical condition.
10. **Primary Care Physician (PCP):** I understand that I must have an active PCP while being treated by the MGH Pain Center. If I change PCP's I must notify the Pain Center and provide the name, address and phone number of my current PCP. I understand that the Pain Center physician will communicate with my PCP to provide updates of my treatment plan and that I will be returned to the care of my PCP at the discretion of the MGH Pain Center physicians.

I have been provided with a copy of this agreement and understand that I may discuss any questions or concerns about the contents with my physician at any time.

Signature of patient ____ Date:________________

Signature of physician: ____

Review date: ______________________

Review date: ______________________