AGREEMENT FOR POSSIBLE USE OF CONTROLLED MEDICATIONS
between Great Lakes Pain Management and
Name_____
__
I understand my treatment may include potent medications which are highly effective when taken as directed under medical supervision, but they also have potential for misuse and abuse. Some of the medications prescribed have the potential for physical and psychological dependence.
Therefore I agree:

NOT to take pain control prescriptions from any other physician.
NOT to take more medications then what is prescribed by my physician.
NOT to be irresponsible with my medication because they WILL NOT be replaced if lost.
NOT to share or give my medication to anyone.
NOT to use any illicit/illegal substances.

I WILL take random drug testing at my physician's discretion.
I WILL use one pharmacy for filling all my prescriptions.
I WILL notify the Pain Center when I need a refill at least 3 days prior to my refill date.
I WILL notify the nurse if someone other then myself(you may designate only one person) will be
picking up my prescription that person will be at least 18 years old and will have to show a photo ID.
I WILL notify the Pain Center if I need to use another pharmacy for any reason.
I WILL report stolen medications to the police and provide a copy of the police report to the office.
I WILL notify my physician and get medication instructions if I have surgery by any other physicians.
I WILL be expected to participate in treatment program recommended by my physician.
I WILL keep my appointments and am aware if I miss an appointment I may not get my prescriptions
until I see my physician.
I WILL show my photo ID when I come to pick up my prescription.

I UNDERSTAND that Great Lakes Pain Management Staff
MAY confer with my pharmacist(s) regarding my medication profile.
MAY confer with my family regarding my medication use.
MAY confer with my family about issues that my physician or family deems necessary.
WILL NOT tolerate verbal abuse or harassment.
EXPECT compliance with my treatment plan to continue my care at the Pain Center.

I understand that if I violate any of the above conditions, I may be discharged from the

practice. In addition, if the violation involves obtaining prescriptions from another individual or any illegal activity such as altering prescriptions, the incident will be reported to other physicians caring for me,pharmacies and the authorities, local police department,Drug Enforcement agency,etc.

This agreement supersedes all other agreements.
By signing below I indicate that I agree with all terms of the above statement.
I have received a copy of this for my medical record.

PATIENT_____
DATE_____

NAME OF PERSON ABLE TO PICK UP MY PRESCRIPTIONS_____

WITNESS_____
DATE_____