

Name: \_\_\_\_\_

MR # \_\_\_\_\_  
(Or Patient Label Here)

VCU HEALTH SYSTEM  
MCV Hospitals and Physicians  
Richmond, Virginia 23298

PATIENT AGREEMENT FOR  
CONTROLLED SUBSTANCE PRESCRIPTIONS

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The main treatment goal for the management of chronic pain is to improve my ability to function and/or work. The goal is to improve my functional ability for as long as possible and to relieve my suffering. This usually involves many different kinds of treatments and medications that work together to decrease pain. My participation and involvement in this management plan is important for it's success. As a patient at VCU Health Systems, I have certain rights and responsibilities, including the right to effective assessment and management of pain, and the responsibility to follow the agreed-upon treatment plan.

I understand that controlled substance medications (i.e. narcotics, sedatives and others) are useful, but have potential for misuse and are, therefore, regulated by the government. They are intended to relieve pain to improve function, not simply to feel good. I understand that I will become physically dependent on the medication, which means if I stop the medication suddenly, I may develop serious or life-threatening withdrawal symptoms. Because my physician/provider is prescribing such medication for me to help manage my pain, I agree to the following conditions:

1. I agree to help myself by following my providers' recommendation regarding exercise/activity, sleep, diet and the use of tobacco. I will avoid use of alcohol and all illegal drugs. I understand that only by following my providers' recommendations for healthy living can I hope to have the most successful outcome to my treatment.
2. I understand that my pain will be assessed and monitored on a regular basis to see how the treatment plan is working. I will discuss my response to the treatment plan with my provider or his/her staff so that the best plan to manage my pain can be developed. If I fail to achieve agreed-upon goals for pain relief and improvement in overall functioning, my controlled substance medications may be gradually tapered.
3. I agree to follow the recommendations of Dr/NP \_\_\_\_\_ and his/her staff to manage my pain and other contributing health conditions. This includes the recommendations of any other provider/clinic to which I have been referred by my provider or his/her staff. If I have problems following these recommendations or have possible side effects or problems related to my medications or treatments, I will discuss them with my provider or his/her staff.
4. I will not seek treatment from an emergency department or another provider for my chronic pain without prior discussion with Dr/NP \_\_\_\_\_ or his/her staff. If I am unable to contact Dr/NP \_\_\_\_\_ prior to going to the emergency department due to the nature of the emergency, I will inform Dr/NP \_\_\_\_\_ that I have gone to the emergency department as soon as reasonably possible afterwards. I understand that seeking care on my own from other providers may lead to situations that could be dangerous to my health.
5. I am responsible for my controlled substance medications. I will use these only in the manner and at the dose prescribed for me. If the prescription for medication is lost, misplaced, or stolen, or if I use it up sooner than prescribed, I understand it will not be replaced. If there is a discrepancy between the amount prescribed and the amount dispensed by the pharmacy, it is my responsibility to discuss this with the pharmacy.

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6. I will not request or accept controlled substance medication from any other physician or individual while I am receiving these medications from Dr/NP \_\_\_\_\_. The only exception is while I am admitted to a hospital. I will not accept prescriptions for controlled substances at the time of discharge. I will contact Dr/NP \_\_\_\_\_ before I am discharged if I have concerns that my previously prescribed medications may not provide enough pain control.
  7. Refills for controlled substance medications:
    - Will be made only during regular office hours according to the policy of my provider's office.
    - Will not be made at night, or on holidays, or on weekends.
  8. Some of my prescription medications may cause drowsiness. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.
  9. I will use only one pharmacy for all of my controlled substance medications and give my provider and his/her staff full permission to communicate with the pharmacist about my medical care and medication. The name of the pharmacy is \_\_\_\_\_ and the telephone number is \_\_\_\_\_.
  10. I will keep all scheduled appointments with Dr/NP \_\_\_\_\_ or his/her associates or reschedule at least 24 hours in advance of the appointment according to the policies of my provider's office. Failure to do so and repeated missed appointments for any reason is a violation of this agreement.
  11. I will bring in the original containers from the pharmacy for all medications prescribed each time I come in, even if there is no medication remaining.
  12. I may be called at any time to come in to the clinic with short notice (\_\_\_\_\_ hours) for a count of all my remaining medication(s) and/or to provide blood or urine samples. Failure to do so is a violation of this agreement.
  13. I agree to notify all providers involved in my care of this agreement.

If I violate any of the conditions of this agreement, my controlled substance medications may be gradually tapered or stopped.

I agree that the risks and benefits of my controlled substance prescriptions have been explained to me by Dr/NP \_\_\_\_\_.

I have read and fully understand this agreement and the consequences of violating it.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date