CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (narcotics, tranquilizers, and barbiturates) are very useful but have a high potential for misuse and abuse and are, therefore, clearly controlled by the local, state, and federal governments. They are intended to relieve pain or to improve function and/or ability to work and not simply to feel good. Because my doctor is prescribing such medication for me to help manage my pain, I agree to the following conditions:

1. **I AM RESPONSIBLE FOR MY CONTROLLED SUBSTANCE MEDICATIONS.** If the prescription or medication is lost, misplaced, or stolen or if I use the medication other than prescribed and run out of the medication, I understand that **IT WILL NOT BE REPLACED.**
2. **I WILL NOT REQUEST OR ACCEPT** controlled substance medication from another physician or individual while I am receiving such medication from Dr. Varughese or other provider. It is illegal to do so (NRS 453.391) and may endanger my health. The only exception is if it is prescribed while I am admitted to the hospital.
3. **REFILLS OF CONTROLLED SUBSTANCE MEDICATIONS:**
    1. Will be taken only on Monday, Tuesday, and Wednesday from 8:30 AM until 4:30 PM. I understand I must allow **5 working days for refills to be authorized by my doctor. All refills will be written. Refills will not be made at night, holidays or weekends.**
    2. In the event of excessive refill requests, I may be required to come in for reassessment before the refill is authorized.
    3. Refills will not be made “if I run out early”. I am responsible for taking my medication in the dose prescribed and for keeping track of the amount on hand.
    4. Refills will not be made on an “emergency basis” such as Friday afternoon because I realize that I will “run out over the weekend”. I must keep track of the medication and plan ahead.
    5. I will call in at least 24 hours ahead if I need assistance with a controlled substance medication prescription.
4. I understand that **IF I VIOLATE ANY OF THE ABOVE CONDITIONS, MY CONTROLLED SUBSTANCE PRESCRIPTIONS AND/OR TREATMENT MAY BE ENDED IMMEDIATELY.** If there is a violation involved in obtaining controlled substances from another individual as described above, I may also be reported to my other physician, local, and medical facilities, and other authorities.

I understand **THE MAIN TREATMENT GOAL IS TO IMPROVE MY ABILITY TO FUNCTION AND/OR WORK. IN CONSIDERATION OF THAT GOAL, I AGREE TO HELP MYSELF BY FOLLOWING BETTER HEALTH HABITS;** specifically involving exercise, weight control, and the use of tobacco or alcohol. I understand that only through following a healthy lifestyle can I hope to have the most successful outcome to my treatment.

PATIENT PRINTED NAME:____

PATIENT SIGNATURE: ______________________________ DATE:____________________