Narcotic Medication Policy and Agreement

In accordance with Delaware Division of Professional Regulation, we wish to inform you of our policy regarding prescription medication for pain. It is the policy of the Physicians and Physician Assistants of Orthopaedic Associates of Southern Delaware, PA, to minimize the use of opioid pain medication due to the addictive nature of these medicines.

If opioid analgesic medications are required as determined by a history and physical examination, the physician shall prescribe for the minimum quantity and potency needed to treat the expected duration of pain and improve the patients ability to function.. I understand that these drugs can be very useful, but have a high potential for misuse and abuse and are therefore closely controlled by the local, state and federal government. Because my physician or healthcare provider is prescribing this type of medication to help manage my pain, I agree to the following conditions:

1. I will take the medication prescribed to me at the dose and frequency prescribed. I understand that I will not increase my dosage without a discussion with my provider. I understand that I am responsible for my medication. If I lose my prescription or require an early refill for any reason, I understand the refill request will be evaluated by a provider. I understand that in these instances I may not receive another prescription, resulting in being without medication for a period of time.
2. I understand no refills of pain medication will be provided after hours or on weekends.
3. I understand I will not obtain pain medication from any other source unless I am hospitalized (excluding ER visits), or have surgery, without first discussing this with my OASD provider.
4. I will not give to, share with, trade with, or sell my medication to another person for any reason whatsoever. Failure to comply could lead to a severing of my treating relationship with OASD providers.
5. I understand that my medication therapy may be re-evaluated, tapered or discontinued by my provider for reasons including but not limited to violation of the treatment agreement or lack of effectiveness.
6. I understand and agree that I will not abuse alcohol or other medically unauthorized substances or medications while undergoing medication therapy with Orthopaedic Associates.
7. I understand that any chronic pain management prescriptions are provided by a single prescriber.
8. I understand that I may be asked to provide a fluid sample for a drug screen at random intervals as part of monitoring compliance with my opioid pain medication treatment regimen. I understand that this is at the discretion of my doctor, but not less than every six months in the State of Delaware. I understand that if I decide not to provide a sample, my doctor may change my treatment plan including not starting opioid pain medication or safely tapering and discontinuing the medication.
9. I agree to allow my provider to contact any healthcare professional, prescription monitoring program (PMP), or pharmacy to obtain or provide information about my care or actions if my prescribing provider deems it necessary
10. I further understand that any violation in this agreement may result in action deemed appropriate by my prescribing provider.

I understand and have read the Pain Management Policy and Agreement above. I understand that failure to comply with any and all of the above may lead my healthcare provider to terminate prescribing, safely taper or discontinue my medication.

_____ _____

Print Patient Name DOB

_____ _____

Patient/Guardian Signature Date

_____

Witness

Effective 04/06/2023