MARTIN MEDICAL CENTER, PC

CONTROLLED SUBSTANCE PROTOCOL

We believe that all patients have the right to adequate pain control. Before we regularly prescribe any medication that is designated by the DEA to be a controlled substance, we would like to make you aware of the guidelines established by Martin Medical Center, PC for taking these medications. We would also like for you to be aware of the possible risks of taking this type of medications.
The conditions of Martin Medical Center monitoring your pain medications are as follows. Please initial next to each number that you have read and agree to each:

1. ___________I have pain that has not been adequately controlled with other medications and my function is limited by my pain. I understand that the intent of the medication is to increase my ability to do more, though the medication is unlikely to eliminate my pain completely.

2. ___________I will not receive any medications for pain control or sleep from any other physician's or dentist's office. If medication is prescribed to me by another healthcare professional, I will call and advise you immediately so that you can continue to monitor my pain medication.

3. ____________I will use only one pharmacy for my prescriptions and refills and my doctor may provide this pharmacy with a copy of this agreement. If I change pharmacies I will notify your office immediately. Pharmacy Name:______________________ Pharmacy telephone #:____________________________.

4. ____________I understand that medications **will not** be refilled early. Under no circumstances will medications be replaced due to loss by theft, misplacing prescriptions, etc.

5. ____________I will follow the instructions provided on the medications. I should not operate heavy machinery, drive an automobile and will notify my employer if I am employed in a safety sensitive occupation. I understand that these medications can be highly addictive. I should not take other sedatives, pain medication or use alcohol while taking this medication unless approved by my doctor.

6. ____________ The medications are being prescribed for **ME.** I will not "share", "loan", or sell any of the medications prescribed to me by Martin Medical Center.

7. ____________ My physician's office may call me at any time and require that I come into the office for evaluation or lab work. I may be asked to bring my medication in so that my doctor can count it to see that I am taking it as prescribed.

I, ____, understand that my patient/doctor relationship with the physicians of Martin Medical Center will be immediately terminated if any of the above guidelines are violated. I understand that Martin Medical Center has the right to call my pharmacy to discuss my medications. I have read the above guidelines for pain control management and understand the risks of these medications. I will follow the guidelines established above.

____ ________________
Patient Signature Date

____ ________________
Physician Signature Date