

# DESERT INSTITUTE FOR SPINE DISORDERS, PC

## Controlled Substance Protocol

One or more of the medications that your doctor has prescribed to for your pain are classified as **controlled substances**. These medications are very helpful in treating pain and returning patients to work, yet they are subject to abuse. For this reason, the state and federal government closely controls this class of medication. So that we may minimize the possibility of complications associated with the use of controlled medication for pain management, we ask that you read and agree to the following.

Controlled Substances covered by this agreement include, but are not limited to: **Oxycontin, MS Contin, Percocet, Percodan, Norco, Vicodin, Lortab, Lorcet, Darvocet, Darvon, Codein, Soma, and all barbiturates and tranquilizers**. If you have any questions as to what drugs fall under this agreement, please ask your physician.

**Common side effects and complications** associated with the use of controlled substances include disorientation, decreased alertness, increased risk when operating motor vehicles and other machinery, drowsiness, confusion, constipation and other problems. Prolonged use of these medications may lead to a problem called **tolerance** (where increasing amounts of medication are needed to provide the same level of pain relief). Tolerance may in turn lead to **habituation and addiction** (where the body becomes used to taking the medication and sudden discontinuation of the drug leads to **withdrawal**).

**As a patient of DESERT INSTITUTE FOR SPINE DISORDERS (DISD), I agree to the following:**

1. While I am receiving controlled medication from DISD, I will not accept or request any controlled substance from any other physician or source.
2. I am fully responsible for all medication prescribed, and will control such medication in my possession. If any medication is lost, stolen, or if I use more than directed, I understand a new prescription will not be written or called into a pharmacy prior to the anticipated end of the original prescription. I am responsible for taking my medication as directed and keeping track of the remaining medication.
3. I understand and agree that refills of controlled substances will only be provided during regular office hours 8am to 4pm. No medication will be refilled on the weekend, holidays, or after hours. Refills requested before 12 Noon will be filled within two business days. I will call in my refill request no later than 4 business days prior to running out of medication.
4. I will provide remaining bottles of medication, with any remaining medication contained therein, to the pharmacist or my physician if requested.
5. Because many illicit drugs and other medication can cause fatal complications when mixed with controlled substances, I agree to drug screening if requested by my physician. Refusal on my part may constitute a violation of this controlled substance agreement.
6. So that potential drug interactions may be avoided, I affirm that I have provided my physician with a complete list of other medication that I am taking.

I understand that this protocol is intended to aid my treating physician, and that it is my responsibility to inform my physician of any side effects or complications that may arise from my use of this medication.

My signature below and, use of the medication prescribed, indicates that I understand and accept the information and conditions outlined above. I agree that if I am unable to adhere to this agreement, my DISD physician will no longer prescribe this class of medication.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_