Headache
© 2006 by American Headache Society
Published by Blackwell Publishing

ISSN 0017-8748
doi: 10.1111/j.1526-4610.2006.00401.x

Headache Toolbox

Controlled Medication Agreement

Your doctor, _____, has decided to prescribe a controlled medication for the treatment of your headaches. The prescription of opioids ("narcotics") and many other medications used for the treatment of pain is regulated strictly by the Federal Drug Enforcement Agency (DEA) and by state authorities. Your physician will write for the type, quantity, and dose of medication that in his/her best judgment is appropriate for the treatment of your headaches; in your particular case, the medication(s) being prescribed is/are _____. By signing this agreement you voluntarily are pledging to adhere to the following regulations.

1. I understand that the prescriptions and medications I receive under the terms of this agreement are my responsibility once they are placed in my hand. If anything happens to the prescription or medication (eg, it is lost, stolen, damaged, etc.), I will not request a replacement prescription; to assist with symptoms that I may experience consequent to withdrawal from the medication in question, a prescription for clonidine may be called into my pharmacy. If my prescription or medication was stolen, I will be required to provide a police report on or before my next scheduled appointment. I understand that the medication being prescribed for me must be kept in a secure location.
2. I will follow the prescription schedule written by my physician, including the date of my next refill and the number of refills. I understand that if I use more medication than the amount prescribed for the time indicated, no additional medication will be prescribed until the refill date. If I repeatedly request early refills of my pain medication, I understand that my physician may decide to stop prescribing that medication altogether.
3. I will only obtain prescriptions for the controlled medications indicated above from _____. If I receive controlled medication from another source for a new or worsening condition, I will notify him/her of this as soon as possible.
4. I have informed my physician of any past or present use of alcohol or other recreational drugs. I understand that I should not drink alcohol or use other recreational drugs while taking controlled medications.
5. I understand that prescriptions for the controlled medication(s) indicated above will not be called in or written after office hours by my physician or a physician covering for him/her.
6. I understand that controlled medications may impair the mental or physical ability required to perform potentially hazardous tasks such as driving a car or operating any dangerous or motorized vehicles or machinery. I understand that I should not perform such tasks if the controlled medication I am taking clearly is impairing those abilities.
7. I understand that the controlled medication(s) may be discontinued by my physician if I fail to achieve the treatment goals he/she has set. I understand that treatment will be discontinued if I obtain controlled medication from other sources, fill my prescriptions for controlled medication at multiple pharmacies, sell, give away, or otherwise divert the controlled medication from its intended use, alter my prescription in any way, change my dosing regimen without first consulting with my treating physician and receiving his/her assent or miss three consecutive appointments (cancellation or no show).
8. I will use only one pharmacy (name: _____/ telephone number: _____) to fill prescriptions for the controlled medication(s) indicated above. If I need to change my pharmacy, I will notify my treating physician.
9. I understand that my urine, blood, or both may be tested at any time to determine the presence or absence of the controlled medication(s), its metabolites, or other controlled or illegal substances in my system. I understand that I may be required to bring in my medication for the treating physician to inspect.
10. I give my consent for the treating physician or any member of his/her staff to speak with my pharmacist or other physician whose care I am under to exchange pertinent information regarding my medical condition.
11. I understand that I must have an active primary care provider (PCP) while receiving controlled medication(s) from the treating physician listed in this agreement. If I change PCPs, I understand that I must notify the treating physician and provide him/her or a staff member with the name, address, and telephone number of my new PCP. I understand that the treating physician will communicate with my PCP to provide treatment updates and that I may be returned to the care of my PCP at the discretion of the treating physician.
12. I understand that risks associated with long-term use of controlled medications may include physical dependence, tolerance, constipation, sleep changes, potential for an eventual increase in pain, injury to unborn children, appetite change, impaired coordination, and impaired sexual desire or performance. I understand that stopping controlled medication abruptly can cause withdrawal symptoms.
13. I understand that if I violate any portion of this agreement, my treating physician may decide to terminate our professional relationship. I understand that my treating physician is under no obligation to provide me with medication for acute or chronic pain if he/she feels such treatment has not proven to be sufficiently effective.

I have been provided with a copy of this agreement and understand that I may discuss any questions or concerns I have regarding its content with my treating physician.

Signature of patient: _____ Date: _____
Signature of Physician: _____
Witness: _____