



SXM SYMPTOM MEDICINE
Pain Medicine, Palliative Care, Anesthesia

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CONTROLLED SUBSTANCE AND OPIOID CONTRACT

Date _____

Patient Name

MR#

A federally controlled substance is a drug or chemical substance whose possession, distribution (including prescriptions) and use are regulated under the DEA Controlled Substances Act, Title 21, Chapter 13. In addition, the California Health & Safety Codes has rules and regulations regarding controlled substances and prescription medications. DEA Controlled Substances and opioids are prescribed on a case by case basis. Not all patients are appropriate for some or all of these medications. It is important to know, in some instances opioids will not provide satisfactory relief, can even increase pain or cause unacceptable side effects. Thus, sometimes it is necessary to decrease your dose or discontinue opioids or controlled substances altogether.

Open and honest communication, proper use of opioids and meticulous documentation amongst patient, caretakers, physicians, and pharmacists is the strongest prevention for misuse, abuse and diversion. Thus, Symptom Medicine (SxM) has a strict opioid, controlled substance and clinic policies. To be considered for prescriptions, Symptom Medicine first requires patients to adhere to this agreement and all clinic policies. You must first read the Controlled Substance and Opioid Educational Module in its entirety. Your acknowledgment of completing the education pamphlet will be recorded on-line, clinic policies forms, and/or the opioid contract. Above all, you must always be under the care of Primary Care Physician (PCP), and your referring physician and primary care physician must be in agreement with your care plan and medication regime prescribed by Symptom Medicine

To be considered for controlled substance prescriptions, you will be required to disclose all of the pharmacies and physicians you receive your prescriptions from, complete a PAR form, and undergo toxicology screening. This screening will continue randomly throughout your care at SxM. Be aware that DEA controlled substances Class II and Class III prescriptions will be only for a two to four week supply. Prescriptions will not be post dated or refilled early. Prescriptions will not be mailed. When taking your prescriptions as directed, you will have a sufficient amount of medication to last until your next appointment. Prescriptions will only be continued if you have been seen and evaluated by a physician, are taking your medications as directed, are displaying a beneficial effect, and are not having intolerable side effects.

Any violation of this contract is grounds for discharge from the Symptom Medicine Clinic. Circumstances that will result in the discontinuation of all controlled substance prescriptions and your discharge from the clinic include, but are not limited to improper use, improper acquisition, selling, drug seeking behavior, violence, aggression, frequent ER visits, frequent clinic calls for early or additional controlled substance prescriptions, multiply requests from one or more physicians for controlled substance, diversion, obtaining multiple prescriptions from different providers and so forth. In some instances, Symptom Medicine will be required to inform the local and state authorities of misuse or illegal use of controlled substances. If it is necessary to discharge you from the clinic, you will be referred back to your PCP for the continuation of medical care. In addition, you may be referred to an addiction specialist, given a 30 day written notice of discharge and provided with a list of specialists in the community. If SxM is prescribing any controlled substances, including opioids medications, the clinic may need to taper your medications down with the goal of discontinuation. To cover your transition back to your PCP, the clinic may give you a prescription for medication that will last for two to four weeks.

Your physician referred you to Symptom Medicine for specialized care. Your referring physician, _____
_____, PCP _____ and SxM physicians, have agreed that any DEA
Controlled Substances, Class II, III, and IV prescribed for your pain syndrome and symptom management

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management will be obtained only from the physicians at the Symptom Medicine Clinic. These classes of medications include, but are not limited to opioids, benzodiazepines, tranquilizers, hypnotics, mood stabilizers, muscle relaxants, anticonvulsants and barbiturates.

1. Symptom Medicine is a consultation service, and cannot act as Primary Care Physician (PCP). Thus, to be a patient in this clinic, I understand I must always be under the care of a PCP. If I have a change of PCP's, I will notify Symptom Medicine within 15 days.
2. I understand that if I am not under the care of a PCP while I am a patient at SXM, I will be discharged from the clinic.
3. At any time during my care at Symptom Medicine, I may be required to be evaluated by an independent psychologist or psychiatrist specializing in pain management to continue care and/or prescribe any controlled substances, including opioids. I understand, consultation services from a psychologist or psychiatrist, are not provided, covered or paid for by SxM.
4. I will disclose all of my treating physicians, treatment clinics, hospitals, medications and pharmacies. I will notify SXM of any changes in these.
5. Obtaining or requesting controlled substances from emergency rooms, urgent care clinics, multiply providers or the Symptom Medicine Clinic is not acceptable, and is grounds for SXM clinic discharge.
6. I will inform SXM if I visit any ER, clinic, and hospital for pain control, symptom management or any change in my health. I will also inform the clinic of any new medications prescribed by another health care provider.
7. I understand health information may need to be exchanged between governmental agencies, pharmacies and/or health care providers regarding my prescriptions and medication use.
8. I will only use prescribed medications as directed by my physician.
9. I will inform my doctor at once if I have any of side effects, or an allergic reaction such as hives; difficulty breathing; rash, itching, swelling of your face, lips, tongue, or throat.
10. I will not share, sell or give away your prescribed medications.
11. I understand controlled substances can cause sedation, slow motor function and impair cognitive function. Thus, negatively affect my ability to drive a motor vehicle, operate machinery, and care for others. If I am under the influence of any controlled substance, including opioids, I will not participate in any activities such as driving any motor vehicle, operating any machinery, working at elevated heights, or caring for others, to name a few
12. Prescriptions will only be refilled at scheduled appointments with the physician and if taken as directed, I will be sufficient amount of medication to last until my next appointment. I understand repeated phone calls, greater than 3, for early prescription (Rx) refills, misplaced Rx, lost Rx can result in the discharge from the clinic
13. I understand that if benefit cannot be ascertained from any prescription medication I am taking, future prescriptions may NOT be given or may need to be changed.
14. I must keep all opioids and controlled substances in a secure place where children and others do not have access to them.
15. Strict accountability and monitoring is necessary for all prescribed medications, this includes, but not, limited to opioids, benzodiazepines, tranquilizers, barbiturates, hypnotics. I understand I must keep track and account for all medications and all prescriptions given to me.
16. For whatever reasons, if I am unable to locate my medications or prescription, I will need to file a police report and bring a copy of it into the clinic to obtain a replacement prescription. If this occurs more than one time a year I will be discharged from the clinic.
17. I understand, if there is any misuse or diversion of my prescriptions, I will be discharged from the clinic, and may be referred to an addiction specialist. A police/DEA report may be necessary.
18. I understand that if I exhibit addictive-like behavior to any controlled substance, I will be referred back to my primary care physician for a consultation with an addictions specialist. Further controlled prescription will need to be determined on a case by case basis.
19. I understand, every SxM clinic patient is subject to periodic random laboratory tests, including blood and/or urine toxicology screening (drug screening).
20. Females of child bearing age— Because of the potential harm to a fetus, I will need use some type of birth control method during my treatment at SXM. If I intend on becoming pregnant or become pregnant, I must notify the clinic as soon as possible. I understand SxM may complete periodic pregnancy tests.
21. Males—opioids can decrease testosterone levels. I understand that my doctor may monitor my testosterone levels.

I understand that if my toxicology screen is consistent with unauthorized medications, non-prescription substances, or inconsistent with my current medications, it is a violation of this contract and will result in a discharge from the clinic. I will be referred back to my primary care physician the continuation of care and a recommendation for a consultation by an addictions specialist.

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22. Disruptive, threatening aggressive or abusive behavior by any patient or person related to the patient will not be tolerated and will result in a discharge from the clinic if necessary a police report will be filed.

I, _____ have read and understand the Controlled Substance and Opioid Educational Module and received a copy. All of my questions were asked and answered.

I, _____, hereby agree to the all of the terms of the clinic policy and opioid and substance medication contract. All of my questions were asked and answered. I understand that if I am unable to meet any one of the conditions of the Terms of Service, Clinic Policy or Controlled Substance Contract, I will discharged from the clinic and all further medical care will be continued with my primary care physician.

Patient Signature	Name:	Date and Time
Patient Representative Signature	Name: and Relationship	Date and Time
Witness Signature	Name:	Date and Time