ORTHOPEDIC CENTERS OF COLORADO
Denver Spine Surgeons

Orchard Falls
7800 East Orchard Road #100
Greenwood Village, CO 80111
Ph: 303-697-7463
Fx: 303-783-1200

In order to provide efficient and timely refill on any of your prescriptions – please note the following;

All refills requiring a written prescription are processed Monday through Wednesday and require an advance notice of 48-72 working hours to allow adequate time to process. You will be notified when your prescription is available for pickup in our office. We are unable to mail, FedEx, or overnight written prescriptions – these must be picked up in the office during regular business hours.

For phone in prescriptions please anticipate your medication needs for the week and call your pharmacy 4 to 5 days before you will be out of you medication. This should allow for adequate time for the pharmacy to notify us, your refill to be approved, and to have it filled by the pharmacy.

Absolutely no prescriptions will be done over the weekend.

Only one physician may prescribe pain medications. If you are currently receiving pain medication from another doctor, we will not refill this medication for any reason.

Refill requests and pharmacy messages are to be left on extension 146 only!

Thank you for your assistance.

Dr. Sanjay Jatana

Initial_____

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Patient Contract for Pain Management and Medication Agreement

This agreement between _____ (the patient) and _____ (the physician) is for the purpose of establishing an agreement between the doctor and patient on clear conditions that the patient agrees to in order to receive pain medications. This may include the care from multiple disciplines, including diagnostic and/or therapeutic interventions, behavioral medicine (psychology, psychiatry, coping strategies, biofeedback), alternative therapies, physical therapy and the prescription use of medications. The doctor and patient understand that this agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship. The medication will probably not completely eliminate your pain but is expected to reduce it enough that you may become more functional and improve your quality of life.

I agree to and accept the following conditions for my pain management:

_____1. I understand that strong medications, which may include opioids and other controlled substances, may be prescribed for pain relief. I understand that there are potential risks and side effects involved with taking any medications, including the risk of addiction. Overdose of opioid medication may cause injury or death by stopping breathing. This may be reversed by emergency personnel if they know I have taken opioid painkillers. It is suggested that I wear a medical alert bracelet or necklace that contains this information. Other possible complications include. But are not limited to, constipation which could be severe enough to require medical treatment , difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function.

_____2. I realize that it is my responsibility to keep others and myself from harm. This includes the safety of my driving and the operation of machinery. If there is any question of impairment of my ability to safely perform any activity, I will not attempt to perform the activity until my activity to perform the activity has been evaluated or I have stopped the medication long enough for the side effects to resolve. This applies to all medication prescribed to me.

_____3. I realize that all medication have potential side effects and interactions. I understand and accept that there may be unknown risks associated with the long term use of the substances prescribed.

_____4. I understand that if I am pregnant or become pregnant while taking medications, my child could be physically dependent on the opioids, and withdrawal can be life threatening for a baby. If a female of childbearing age, I certify that I am not pregnant and I will use appropriate contraceptive measures during the course of treatment with medications. Many medications could harm the fetus or cause birth defects.

_____5. I understand I must contact my physician before taking tranquilizers, benzodiazepines or prescription sleeping medications. I understand that the combined use of various drugs, opioids, as well as alcohol, may produce confusion, profound sedation, respiratory depression, blood pressure decrease, and even death.

_____6. I understand that opioid analgesics could cause physical dependence within a few weeks of starting opioid therapy. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (including nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose.

_____7. Withdrawal from other medications can also have serious consequences, including the risks of injury or death. I will not discontinue any medication I take regularly without consulting my physician.

_____8. I agree that continue refill of medications may be contingent upon compliance with other pain treatment modalities recommended by my doctor.

_____9. Timely requests for refills of medications are the patient's responsibility.

A. Refill requests for medication requiring a written prescription must be called to the office 48 business hours prior to pickup. **Written prescriptions must be picked up at the office**. Written prescriptions will not be mailed or delivered by any other manner. Refills requests made Thursday or Friday of a given week will not be available until Monday.

B. Refills will not be made over the phone, at night or on weekends. This policy will be strictly adhered to.

C. Refill will not be made if I "run out early" or "lose a prescription" or "spill or misplace my medication" or if some one else has taken some of your prescription. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.

D. Refills will not be made as an "emergency". I will call at least my pharmacy at least 4-5 days prior to needing my prescription(s) that do not require a written prescription.

E. If medications are stolen, and a police report regarding the theft is completed, an exception may be made at the discretion of my physician.

____10. I agree that I will use my medication at a rate no greater that the prescribed rate unless it is discussed directly with my physician.

____11. I will not use any illicit substances (cocaine, heroin, etc.) while being treated with controlled substances. Violation of this will result in the cessation of the prescribing of any controlled substances and termination of my care.

____12. I will not share, sell, or trade my medication or exchange medication for money, goods, or services.

____13. I will no alter my medication in any way (for example: crushing or chewing tablets) or use any other route of delivery (for example: injection or insufflation) other than as prescribed.

____14. I understand that changing dates, quantity, or strengths of medication or altering a prescription in any way is against the law. Forging prescriptions or physician's signature is also against the law. Our office cooperates fully with law enforcement agencies in regards to infraction involving prescription medications.

____15. I will discontinue all previously used pain medication, unless told to continue them by my physician. I will keep this office informed of all medications I may receive from other physicians.

____16. I agree that I will submit to a blood and/or urine test if requested to determine my compliance with this agreement and my regimen of pain control medication. Tests may include screens for illegal substances.

____17. I will not attempt to get pain medication from any other health care provider without telling them that I am already taking pain medication prescribed by this office.

____18. I understand that once I reach maximum medical improvement postoperatively management of my refills may be transferred to a pain management physician or my primary care physician. If I do not have either a pain management physician or a primary care physician, I will have from 1 to 3 months to find a doctor that will take over my care and prescribe my medications.

____19. I understand that my medication regimen may be continued for a definitive time period as determined by my physician. My case will be reviewed periodically. If there is not significant evidence that I am improving or that progress is being Made to improve my functioning or quality of life, the regimen might be Tapered or possibly discontinued and my care referred back to my primary care physician.

____20. I will keep all scheduled follow up appointments as outlined in my treatment plan. The maximum time between appointments will be 90 days.

____21. I understand that the main treatment goal using pain medications is to improve my ability to function and/or to work and/or to reduce pain. In consideration of that goal, and the fact that I may be given potent medication to help me reach that goal, I agree to help myself by following better health habits. This may include exercise, weight control, and avoiding the use of nicotine. I must also comply with the treatment plan as prescribed by my doctor.

____22. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my pain medications and I authorize the doctors, my pharmacy, and insurers to cooperate fully with any city, state, or federal agency in the investigation of any possible misuse, sale, or other diversion of my pain medication.

____23. I authorize my physician to provide a copy of this agreement to my pharmacy, other healthcare providers, and any emergency department upon request. I give my permission to allow sharing of medical history in regards to medication use with other health care agencies.

____24. My physician and I agree that this agreement is important to my doctor's ability to treat my pain effectively, and that my failure to comply with the agreement may result in the discontinuation of prescribed medication by my doctor and termination of the doctor/patient relationship

____25. I agree to be responsible for the secure storage of my medication at all times. I agree not to give or sell my prescribed medication to any other person. Depending on the circumstances, lost medication may not be replaced until the next regular renewal date and may violate this contract and impact further treatment

____26. I agree to maintain compliance with all state requirements regarding the chronic use of narcotic medications which are consistent with the current office policies of:

- A maximum of 90 days between follow visits
- Urine drug screening
- Daily medication intake equal to or below 120 Morphine Equivalents (MME)
- For patient testing positive for Cannabinoids the daily intake will be at or below 60 MME

I have thoroughly read, understand and accept all of the above provisions. Any questions I had regarding this agreement have been answered to my satisfaction by my physician. I understand all the policies regarding the prescribing and use of opioids and other medications. I agree to comply with the pain management program. I also agree to testing and detoxification if indicated.

Your physician understands that emergencies can occur and under some circumstances exceptions to these guidelines may be made. Emergencies will be considered on an individual basis**.**

Lack of strict adherence to any provision of this agreement by your physician in no way invalidates any other provisions of this agreement.

If at any time you are concerned about your medication or side affects of your medication, you may call the office at 303-697-7463. The on-call physician can also be contacted to receive your message if necessary.

I agree to use _____Pharmacy, located at _____

_____ telephone number _____,

For all my pain medications, if I change my pharmacy for any reason, I agree to notify this office at the time I receive a prescription. I will also advise my new pharmacy of my prior pharmacy's address and telephone number.

This agreement is entered into on this _____day of _____,20___.

_____ **_____**

Patient Signature **Physician Signature**

_____

Witness