Introduction to the DWC Pain Management Agreement

Because of the increased use of narcotic analgesics in this country and with heightened governmental scrutiny of physicians prescribing these drugs, it is essential to set up a verifiable system to assure pain is treated responsibly and all parties are protected.

The Pelvic Pain Program at Desert Women's Care involves simultaneous evaluation by a group of physicians and medical professionals knowledgeable in the various organ systems that can directly cause chronic pelvic pain. During the course of this evaluation pain will most often be treated with a combination of oral non-steroidal anti-inflammatory drugs, non-narcotic analgesic cream and oral short-acting narcotic analgesics.

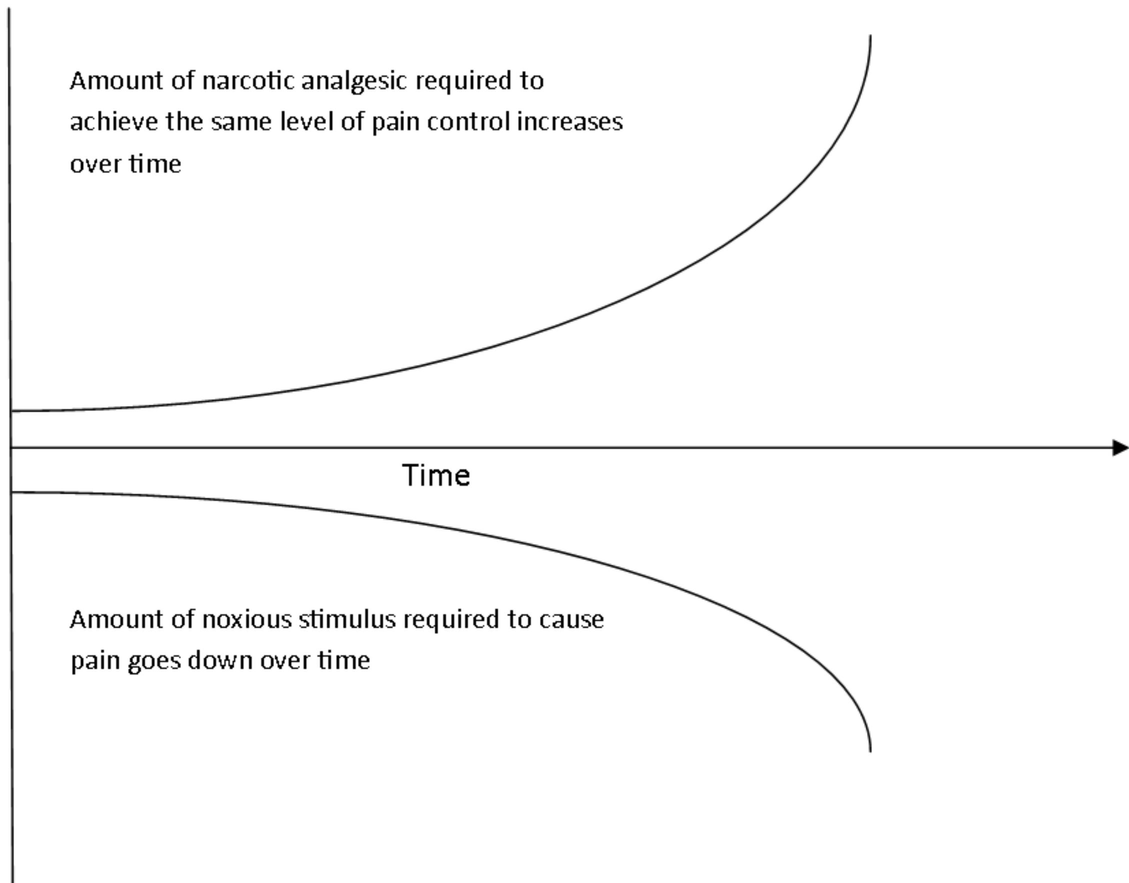
The goal of the Pelvic Pain Program is to determine the cause or causes of a patient's chronic pelvic pain and to appropriately treat the cause as opposed to simply "covering up" the pain with analgesics. To further this goal, patients will see specialists in different areas of medicine. Medical records and this pain contract need to be shared amongst these physicians to coordinate care.

It is the goal of all associated practitioners to effectively treat the root cause(s) of a patient's pain with the intention of completely eliminating the pain. In successful cases, elimination of pain means no further analgesics will be required. Unfortunately, not all patients will have a cause for their pain found, or if found, not all patients will achieve pain-free status. The remaining patients will require chronic pain management.

The management of chronic pain is a complex problem and pain medications may be part of the treatment plan. Opioid analgesics typically only reduce chronic pain by about 30%. Other medications may be prescribed and other treatments pursued to help improve functioning and further reduce pain. "Zero pain" may be an unreasonable goal.

The purpose of this agreement is to protect the safety of the patient and the community and to clearly establish expectations of how use of these medications is to be safely managed. These medications are highly regulated and can cause serious injury or death if misused along with other adverse health consequences such as addiction.

When a patient signs this agreement, it means that she understands that taking opioid pain medications, even as prescribed, may trigger craving for more opiates leading to physiological dependency. Dependency and habituation to opioids can put a patient at risk of developing an addictive disorder.



As time goes on two things happen to a patient taking narcotic analgesics: first, the amount of medication required to get the same level of relief goes up; second, the amount of noxious stimulus required to cause the same level of pain goes down. The end result is patients need more narcotic analgesics and hurt more. Said in another way, taking narcotic analgesics will never completely cure pain but will certainly lead to negative life results.

The attached “Pain Management Agreement” sets forth the circumstances under which Desert Women’s Care will prescribe narcotic analgesics and sets forth patient responsibilities to continue under care.

“Pain Management Agreement”

Patient:____________________ Physician:_____________________________
Patient’s DOB: _____________ Designated Pharmacy: ____________________

1. **_______ONE prescriber for controlled medications and ONE pharmacy:**
I agree to receive pain medications only from my treating physician (named above) or from someone designated by my treating physician. I agree to receive my pain medications only from my designated pharmacy (listed above) unless my treating physician agrees otherwise.

If you receive controlled medications from another health care professional because of a true emergency, injury or accident requiring urgent care, you agree to tell that practitioner (or have a family member/friend tell that practitioner) about your agreement with this office.

If you receive controlled medications from another health care professional, you agree to call this office within 24 hours and tell us who prescribed or gave you which controlled medications and why. This requirement is for your safety and allows us to consider possible drug interactions.

You also understand that you should use the same pharmacy every time you fill a prescription. You agree to call us if there is a reason to use a different pharmacy. This requirement is also for your safety.

2. **______ Drug testing, medication counts and query of Arizona Controlled Substances Prescription Monitoring Program (CSPMP) database:** *I give my permission for urine, saliva or blood screening as requested by my treating doctor at any time. I understand that it is my doctor’s responsibility to make sure my treatment plan is safe, effective and that I am following the treatment plan. A drug screen is a laboratory test of my urine, saliva or blood that I provide to check the drugs that I have been taking. I understand that my drug screening test results will be part of my medical record. I understand that I may be asked to bring in all of my medications at any time to be counted. I also understand my physician will from time to time query the Arizona CSPMP database to assure I am not receiving prescription analgesics from other providers in violation of this agreement. These are measures of how well I am able to follow my treatment plan.*

We use drug testing, pill counts and dispensing records in this practice to look at risk and safety issues. We do not perform drug testing or medication counts to punish you. We do this to monitor risk and safety as required by professional medical guidelines and rules.

3. **______ Take medications ONLY as prescribed.** *I agree to take each of my medications at the prescribed dose and frequency. This means I will not run out early. If I think my medication is not working, or that I am having a medication problem, I will call this office and ask to speak with my doctor for guidance.*

Controlled medications are powerful and can cause harm if not taken according to the doctor's instructions. Using controlled medications in any way other than as directed by your doctor may cause you to have more health problems and could kill you. Follow the written directions on your prescription bottles and call your pharmacist and this office if you have questions.

4. ______ **Medication safety:** *I will safeguard my medications and prescriptions. I understand that lost, stolen or damaged medication will not be replaced. I will store my medications in a safe, secure, locked place to prevent theft, loss or use by others. I will keep all medications away from children of any age.*

Allowing someone else to take your medication can make another person sick or cause them to die. These medications are prescribed for you and only you. We emphasize the safe use, storage, and disposal of all medication. Use medication ONLY as directed.

5. ______ **Is this the right medication for me:** *I understand that my physician may stop, taper, or change my prescribed medication:*

    -*If my activity and functional level have not improved*
    -*If I do not show improvement of pain*
    -*If I develop significant side-effects from the medication*
    -*If I give, sell or misuse any of my medications*
    -*If I demonstrate that I am unable to follow this agreement and my physician feels he can no longer prescribe my pain medications safely and effectively.*

    This will be documented in my medical record.

6. ______ **Agreement NOT to use illegal drugs or other pain medications:** *I agree not to use illegal or street drugs. I agree not to abuse alcohol. I agree not to take any medications prescribed for someone else. I agree not to use over-the-counter medicines or any other medically active substance without the agreement of my treating physician. I may be prescribed medication by another licensed provider and I will notify EVERY treating physician of all medications I am taking. If I am prescribed other or additional pain medications due to surgery or to injury I will notify the health care provider caring for me that I have a pain medication agreement. I will promptly let my pain medicine prescriber know that I have received additional medication. I further understand my provider will regularly query the State of Arizona Controlled Substances Prescription Monitoring Program (CSPMP) database to assure my compliance.*

    Using illegal or street drugs is a bad idea. Using other medication not prescribed by your pain medicine prescriber to treat your pain or pain-related medical problems is a bad idea. If you use illegal drugs or other controlled medications, your doctor may decide to stop prescribing controlled medications for you.

7. ______ **Consent to share this agreement with other health care professionals and the hospital for coordination of my medical care:** *I give my permission for my treating physician to share the contents of this agreement and to discuss all my medical conditions and treatment details with pharmacists, physicians (including Emergency Departments and Urgent Care Centers), or other healthcare professionals for the purpose of coordinating my care. I give permission for all the above to report violations of this agreement to my physician. I understand that this agreement may be added to my medical record at the hospital or out-patient surgical center so that if I do have an emergency visit, or surgery, my treatment plan will be considered. I understand this is to help keep me safe.*

I understand that my permission is not required for my physician and my pharmacy to cooperate fully with any city, state or federal law enforcement agency in the investigation of any possible misuse, sale or other diversion of my pain medicine. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

By signing this document, you agree that we can share this agreement with any health care professional in the coordination of your medical care. In this case, coordination of care means the evaluation of your health, medical treatment and safety issues associated with the use of controlled medications.

Patient signature ____________________________________ Date_________________

Patient name PRINTED ____

Prescribing Physician signature ____

Richard H. Demir, MD

Copy of this signed Agreement to be given to the patient

To facilitate my evaluation and ongoing treatment within the Desert Women's Care Pelvic Pain Program, I specifically grant my permission to provide a copy of my signed "Pain Management Agreement" to the following physicians and organizations:

- Gastroenterology
  Nadim Zyadeh, MD
  2236 West Bethany Home Road, Phoenix, AZ 85015
  (602) 973-6666
- Neurology
  George Wong, MD
  1492 South Mill Avenue, Suite 214, Tempe, Arizona 85281
  (480) 967-6088
- Psychiatry
  The Pain Center of Arizona
  5281 North 99th Avenue, Suite 100, Glendale, AZ 85305
  (623) 241-6120
- Pain Management
  The Pain Center of Arizona
  5281 North 99th Avenue, Suite 100, Glendale, AZ 85305
  (623) 241-6120
- Addiction Medicine
  Greg Ellison, MD
  2127 East Baseline, Suite 104, Tempe, AZ 85283
  (480) 897-7070
- Pharmacology
  Ryan Martin, PhD
  2525 West Carefree Highway, Building 1,Suite 106, Phoenix, AZ 85085
  (623) 806-1300
- Pelvic Physical Therapy
  Dynamic Rehab
  2940 East Banner Gateway Drive, Suite 425, Gilbert, Arizona 85234
  (480) 813-7900

I also give my permission for Desert Women's Care to share my medical record with other physicians and organizations as it deems necessary for the purpose of furthering my medical care.

Sign: ________________________________ Witness: ____________________________

Print: ________________________________ Print: ______________________________

Date : ________________________________ Date: ______________________________