YUKON-KUSKOKWIM HEALTH CORPORATION
P.O. Box 287 • Bethel, Alaska 99559 • 907-543-6000

Controlled Substance Agreement (Pain Contract)

This agreement has 4 parts

Part 1 Tells you how and when to take your pain medicine.

Part 2 Lists things you agree to do.

Part 2 a Lists things that could happen if you do NOT do the things listed in Part 2 a.

Part 3 I understand and know what I need to do and not do.

Part 4 Sign the form. *You and your YKHC provider must sign the form.*

Is the patient over 45?

☐ Yes – You can continue.

☐ No – Narcotics are not recommended.

In the past year has the patient completed:

☐ Impact ½ hour evaluation?

☐ Gone to PT and home exercises?

☐ Has the patient tried 3 types of NON-Narcotic Meds? List them below:

_____ _____ _____

PART 2 THINGS I AGREE TO DO

- I will only get my pain medicine from YKHC Pharmacy.
- I will take my pain medicine as listed in Part 1.
- I will tell my other doctor(s) that I am taking pain medicine.
- I will tell my YKHC provider about ALL of the medicines (over-the-counter, herbs, vitamins, those ordered by other doctors) I am taking.
- I will tell my YKHC provider about all of my health problems.
- I will allow my YKHC provider to talk with other doctors about my health problems.
- I will only ask YKHC's pharmacy for refills 7 to 10 days before I am out of my medication.
  Pharmacy Hours: Monday to Friday from 9 a.m. to 7 p.m.
- I will be courteous to YKHC Staff and YKHC Pharmacy staff during my care.
- I will pick up my certified letters at the post office from YKHC pharmacy and go to all my pill audits.
- I will tell my YKHC provider if I get pain medicine from another doctor or emergency room.
- I will call my YKHC provider's office at least 24 hours in advance if I need to cancel my appointment.
- I will keep my pain medicine in a safe place AND away from children.
- I will get my pain medicine from only at YKHC Pharmacy.
- I will bring all of my unused pain medicine in their pharmacy bottles the next time I come to see my YKHC provider. He/she may count the number of pills in my bottle(s).
- I will allow my YKHC provider to check my urine (pee) or blood to see what drugs I am taking.

PATIENT INFORMATION

Acct. #: _____

HR#: _____ DOB: ___ /___ /___

Name: _____
Last *First* *MI*

Residence: _____ Facility: _____

Date of Service: _____

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PART 2a THINGS I WILL NOT DO

- I will NOT share, sell or trade my pain medicine with anyone.
- I will NOT use someone else's medicine(s).
- I will NOT use illegal drugs (crystal meth, cocaine).
- I will NOT use alcohol and marijuana.
- I will NOT change how I take my medicine(s) without asking my YKHC provider
- I will NOT ask my YKHC provider for extra refills if I use up my supply before my next appointment.
- I will NOT ask for extra refills if I lose or misplace mine, or if they get stolen.
- I will NOT be mean to any YKHC Staff or to any YKHC Pharmacy staff during my care. I understand if I am I will get a strike against me.

PART 3 I UNDERSTAND

- If I do not do all of the things listed in Part 2 a, my YKHC provider:
- will no longer order pain medicine for me.
- may stop giving me medical care.
- may send me to drug abuse treatment.
- If I receive three strikes my pain contract can be cancelled

I know

- My YKHC provider and my YKHC pharmacy may work with the police to look at any misuse or sale of my pain medicine.
- I know if I drive while taking pain medicine, I can be charged with driving under the influence (DUI). If I am charged with DUI
- while taking pain medicine, My YKHC provider is not to blame

Part 4 SIGN THE FORM

*I have reviewed this document and I understand the possible risks and side effects of opioid medications as stated above.**

This agreement is for 6 months. It will expire _____/_____/_____.

_____ _____ _____
Sign your name *Date* *Printed Name*

_____
Translator signature

_____
Street or P.O. *City* *State* *Zip Code*

_____ _____
Current Phone number *Message # or cell #*

_____ _____ _____
My YKHC Provider Name *Date* *My YKHC Provider's Signature*

Make a copy for the patient and scan it into the multimedia in EHR under Controlled Substance

PATIENT INFORMATION

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MY PAIN MEDICINE

Medicine	Breakfast	Lunch	Dinner	Bedtime

Opiates: Opiates are a group of medications which are most commonly used to treat pain. They can have great benefits in this area but they do have risks including addiction. Common examples include Tramadol (Ultram), Hydrocodone (Lortab, Vicodin, Norco, Lorcet), Oxycodone (Percocet, Oxycontin), Morphine (MS Contin), Kadian (Morphine), and Fentanyl (Duragesic).

Common Side Effects of Opiates: Itching, Vomiting, Difficulty Passing Urine, Constipation, Headache, and Drowsiness.

Possible Effects of Overuse: Death, Slurred Speech, Difficulty Thinking, Physical Dependence, Addiction, Passing Out, Slowed Breathing, Decreased ability to have sex. *If you ever experience signs of overuse, contact your provider or the Emergency Department or see your health aide in your village*.

Possible Side Effects of Withdrawal: Anxiety, Muscle Twitches, Diarrhea, Abdominal pain, Sweats, Nausea, Yawning, Insomnia. *For signs of dependence or withdrawal, contact your provider; this is an uncomfortable, but not a deadly condition.*

Benzodiazepines: These medications are commonly used to treat severe anxiety. They can be useful in acute as well as long-term anxiety treatment, but they do have risks including addiction. Common examples include Diazepam (Valium), Lorazepam (Ativan), Alprazolam (Xanax), and Clonazepam (Klonipin).

Common Side Effects of Benzodiazepines: Drowsiness, Depression, Headache, Constipation, Diarrhea, Dry Mouth, Fatigue, Memory Impairment, Reduced Coordination, Physical Dependence, Appetite Changes, and Menstrual Changes.

Possible Effects of Overuse: Death, Addiction, Low Blood Pressure, Difficulty Thinking, Passing Out.

Possible Side Effects of Withdrawal: Anxiety, Elevated Temperature, Elevated Blood Pressure, Rapid Breathing, Confusion/ Delirium, Tremor, Hallucinations, Seizures, and Death. *If you ever experience signs of toxicity or withdrawal, contact your provider or the Emergency Department or see your health aide in your village.*

Tolerance, Dependence, and Addiction: These medications may lead to tolerance, meaning that it takes more medicine to produce the same benefit/effect. Physical dependence is a state where your body has become used to the medication and stopping it will cause withdrawal symptoms. Addiction is a state where one is willing to take medication even if causes harm or involves illegal actions. Any concerns for addiction should be reported to a provider.

Potential Risks of Opioid Treatment

Physical side effects: May include mood changes, drowsiness, nausea, constipation, urination difficulties, depressed breathing, itching, bone thinning and sexual difficulties.

Physical dependence: Sudden stopping of an opioid may lead to withdrawal symptoms including abdominal cramping, pain, diarrhea, sweating, anxiety, irritability, and aching.

Tolerance: A dose of an opioid may become less effective overtime even though there is no change in your physical condition. If this happens repeatedly, your medication may need to be changed or discontinued.

Addiction: Is more common in people with personal or family history of addiction, but can occur in anyone. It is suggested by drug craving, loss of control and poor outcomes of use.

Hyperalgesia: Increased sensitivity to and/or increasing experience of pain caused by the use of opioids may require change or discontinuation of medication.

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Overdose: Taking more than the prescribed amount of medication or using with alcohol or other drugs can cause you to stop breathing resulting in coma, brain damage, or even death.

Sleep apnea: (periods of not breathing while asleep) - May be caused or worsened by opioids.

Risk to unborn child- Risks to unborn children may include: physical dependence at birth, possible alterations in pain perception, possible increased risk for development of addiction, among others. Tell your provider if you are or intend to become pregnant.

Victimization: There is a risk that you or your household may be subject to theft, deceit, assault or abuse by persons seeking to obtain your medications for purpose of misuse.

Life-threatening irregular heartbeat: Can occur with methadone, ekg may be needed.

I have reviewed this document and I understand the possible risks and side effects of opioid medications above.

_____ _____ _____
Sign your name *Date* *Printed Name*

_____
Translator signature

I have reviewed with the patient all of the information above.

_____ _____ _____
YKHC Provider Signature: *Date:* *Printed Name*

Make a copy for the patient and scanned into the multimedia in EHR under Controlled Substance Agreement.

PATIENT INFORMATION

Acct. #: _____

HR#: _____ DOB: ___ /___ /___

Name: _____
Last *First* *MI*

Residence: _____ Facility: _____

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