

## Narcotic Pain Medication Policy

Thank you for choosing Northwest Orthopaedic Specialists for your orthopaedic needs. We will supply appropriate narcotic pain medication for certain acute injuries and postoperative care. Narcotics are considered safe when used appropriately, but side effects may occur, as well as a potential risk of an addictive disorder developing. Side effects for these medications can be, but are not limited to, drowsiness, urinary retention, constipation, itching, nausea, and confusion. We weigh the risks versus the benefits before utilizing these medications. Once we have decided to utilize these medications for pain management, the following conditions **MUST** be met:

1. Pain medications may be supplied for acute injuries and/or a postoperative period following surgery. Time frame may vary based on condition and will be determined by the provider, but will not exceed three (3) months.
2. Additional therapy may be recommended for pain management, which you will be required to participate in.
3. You must maintain the dosing schedule prescribed by our clinic. ANY changes must have prior approval from our clinic.
4. You must not be receiving narcotic medication from any other physician at the same time we are prescribing these medications unless you have an established pain contract with your primary care physician.
5. You must receive your prescriptions from only one pharmacy.
6. You understand that prescriptions that are lost, stolen, accidentally disposed of, or consumed before the appropriate date will not be refilled.
7. We will not dispense narcotic drugs after office hours or on weekends. **NO EXCEPTIONS.**
8. You must call your pharmacy for refills and give **48 HOURS NOTICE** for prescription refills. **NO EXCEPTIONS.**
9. If you require chronic pain medication past the normal acute injury care or postoperative period, you will need to return to your primary care physician for refill consideration.
10. If you receive controlled medications from another health care professional, you agree to inform us of the medications prescribed and by whom.

We reserve the right to discontinue care should you not comply with the above conditions.

**I HAVE READ THE ABOVE CONDITIONS AND WILL ABIDE BY THEM.**

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT PATIENT NAME