

SPORTS MEDICINE OREGON
PRESCRIPTIONS AGREEMENT

Patient: _____ DOB: _____

PLEASE READ BEFORE SIGNING.

I understand that I am to select one pharmacy and call them directly for refills at least 2 business days ahead of time. There will be **NO REFILLS AFTER 4:30 p.m. or on the weekends**, so I will plan accordingly to ensure that I do not run out of medications necessary for my medical treatment. I am also aware that some prescriptions can only be given in writing and may require extra time to pick up or receive in the mail.

ANTI-INFLAMMATORY DRUG PRESCRIPTIONS (NSAID's)

I understand that NSAID's do not take effect immediately and that it may be up to a week before I see results. NSAID's can cause gastrointestinal problems such as diarrhea and upset stomach as well as drowsiness, and although that is rare, I will take them at home for the first time to see how I react. I agree not to take any other over the counter drugs such as Advil, Aleve, or Ibuprofen. Tylenol, if needed, will be fine.

NARCOTIC PRESCRIPTIONS

I am receiving narcotics to treat my medical condition and I understand that there are RISKS associated, such as dependent, addiction, constipation, coordination, bowel obstruction, loss of sexual desire and performance as well as changes in my appetite, sleep habits, or personality.

Respiratory depression can also be caused by narcotics and this can lead to shortness of breath, especially in heavy smokers and in people with lung disease. I will inform you of my smoking practices so that we can discuss the risks to me.

Medication interactions can increase the risks associated with narcotics. The most important of these is alcohol. I will inform you of my drinking practices so that we can discuss the risks associated with drinking and taking narcotics. I will inform you of all medication I am taking while on narcotics, including those obtained "over the counter", as there may be interactions between them and the narcotics I am taking.

To Minimize Risk(s) and to ensure adequate supervision, I AGREE:

- to return for regular follow up visits at the timing required by my physician,
- to report any change in mental state or any adverse reactions,
- to have any lab tests you advise, including blood levels and urine drug screening and to comply with any consultations you deem necessary,
- to provide or assist in obtaining any medication records deemed necessary by my physician,
- **NOT** to mix alcohol with narcotics,
- **NOT** to stop my medications suddenly because that would result in rebound pain and withdrawal symptoms,
- **NOT** to obtain any narcotics from any other physician unless you are notified.

I understand that if my narcotic medication is lost, stolen, destroyed, etc., or used up early, you will not refill it until time for the next regular refill.

Patient Signature: _____

Date: _____