Name:
DOB:
Chart:
Age:
Date:

BAYSIDE ORTHOPAEDIC
SPORTS MEDICINE & REHAB CENTER

NARCOTIC POLICY

At Bayside Orthopaedics, we recognize that the abuse of prescription narcotics has exploded into a national epidemic. In fact, accidental death from overdose of prescription narcotics now exceeds that of heroin and cocaine combined. For the safety of our patients, we are leaning on published guidelines from the CDC for our opioid management strategy. We have established the following agreement and guidelines between our patients and physicians.

As a patient of Bayside Orthopaedics, I, **Name** _____ agree to the following guidelines:

1. I understand that narcotic medication is not to be the only method of pain management but must be used with other long-term methods of pain therapy such as over-the-counter medications, stress management, exercise, and social and vocational activity.
2. I understand that abuse of the medication will lead to termination of the treatment and discharge from the practice. The term "abuse" includes not taking medication as prescribed, selling or trading the medication, sharing the medication, getting medication from another physician, use of illegal or street drugs, and use of another person's medications.
3. I understand that I may select and use only one pharmacy to fill all narcotic prescriptions.
   Name and phone number of pharmacy: _____
4. I understand that I SHOULD NOT operate heavy machinery or operate a motor vehicle while taking my prescribed narcotics, as this medication may impair my judgement and the safety of myself and others. By choosing to do this, I am putting myself and others at increased risk for serious injury or even death.
5. I understand that my insurance may require a prior authorization or limit the supply of my medications.
6. I understand that this is an orthopedic practice and not pain management practice. If long term pain control is needed, this should be directed through my primary care provider.
7. I understand that there will be no phone-in prescriptions provided after hours including the weekend and holidays or other times when the office is closed.
8. I understand that there will be no replacements of lost or stolen prescriptions.
9. I understand it is my responsibility to monitor my medication use and request needed refills 24-48 hours in advance.

I have read and understand the above guidelines. I understand that this document is a contract, by signing I agree with and consent to adhere to these guidelines. I understand that failure to comply with this policy, or otherwise abuse this policy could result in discharge from the practice.

Patient Name: _____ (please print your full legal name)

Patient Signature: _____ Date: _____