SPORTS MEDICINE OREGON
PRESCRIPTIONS AGREEMENT

PATIENT: _____DOB: _____

PLEASE READ BEFORE SIGNING.

I understand I am responsible to notify the clinic of my preferred pharmacy and to call that pharmacy directly at least 2 business days prior to needing a refill. I understand it may take up to 48 hours to refill my prescription after receiving the request from my pharmacy. There will be **NO REFILLS AFTER 12:00 p.m. on Fridays or during the Weekends**, so I will plan accordingly to ensure 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 NSAID's do not take effect immediately and 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 while taking other NSAID medications. Tylenol, (or Acetaminophen) since it is not an NSAID, can be taken if needed.

NARCOTIC PRESCRIPTIONS

If my Provider prescribes narcotics to treat my medical condition, I understand there are RISKS associated, such as addiction, constipation, changes in 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 we can discuss the risks associated with drinking and taking narcotics. **I will inform you of all medications 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 my mental state or any adverse reactions
- to complete any lab tests ordered by my physician, including blood levels and urine drug screening
- to comply with any consultations deemed 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 it could result in rebound pain and withdrawal symptoms
- **NOT** to obtain any narcotics from any other physician unless the clinic is notified.

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

PATIENT/GUARDIANSIGNATURE:_____DATE: _____