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### **Request for Narcotic Therapy**

I, \_\_\_\_\_, am requesting treatment with narcotic pain medication(s) because other therapies, treatments, and/or medication(s) that I have previously received had not provided me with adequate relief of pain. I understand that it is unlikely that any medication(s) will completely remove or eliminate my pain. I further understand that the narcotic pain medication(s) will be prescribed for me for humane reasons **as long as my pain continues**, provided that I follow all terms of this agreement.

### **Potential Complications**

My physician, Edward Rubin, M.D., has discussed potential long-term narcotic therapy with me in detail and I understand some of the possible complications that may occur are:

- Chemical/physical dependence and addiction
- Severe constipation which could require medical treatment difficulty with urination
- Drowsiness
- Nausea
- Itching
- Slowed breathing or respirations
- Reduced or absent sexual desire and/or function

I also understand that if I take more medication than my physician has prescribed serious and life-threatening complication may occur. Serious complications include but are not limited to:

- Coma
- Organ damage or failure death

I further understand that if I take all my medication(s) sooner than prescribed or if I suddenly stop taking my medication(s) that I could have narcotic withdrawal symptoms that can be very painful and life threatening.

(Female patients only) I understand that there are both known and unknown hazards/risks to an unborn infant if the mother takes narcotic medication(s). The risks/hazards include but are not limited to narcotic addiction of the infant with narcotic withdrawal after birth. I, \_\_\_\_\_ assume full responsibility for notifying my physician if I suspect or confirm that I am pregnant. I further understand that a different plan of treatment, without the use of narcotics, will be tried during pregnancy.

### **Terms/Agreements**

This narcotic agreement is contingent on compliance with ALL of the following patient and physician terms:

1. I agree to receive narcotic medications prescriptions ONLY from the physician(s) at our center
2. In order to obtain a refill for narcotic medication(s), I understand that an appointment must be scheduled with the physician. I further understand that it is my responsibility to assure that I have enough medication to last through the weekend, holiday, and/or after hours (4pm-8am).
3. I understand that Edward Rubin, MD does not accept telephone requests for narcotic prescriptions and I must be seen at my regularly scheduled appointment with the physician to receive a narcotic prescription.

4. In the case of another physician(s) on-call after hours, on holidays, and on weekends will **NOT** refill my medication. It has been explained to me that they do not have charts available for review to make decisions regarding medications.
5. I agree to be under the care of a primary care physician. I will inform Edward Rubin, MD if I change my primary care physician. My primary care physician is : \_\_\_\_\_
6. I hereby authorize a release of information that allows the physician(s) and/or staff to communicate and collaborate with any other health care provider(s) currently involved in my care, as well as, those previously involved in my care.
7. I understand that at Edward Rubin, MD there are many different professionals on staff who work together with a team approach to treatment. I further understand that the team will meet and discuss my treatment plan and progress and give permission for the team to discuss my plan and progress.
8. I will notify Edward Rubin, MD about medication side effects.
9. I understand that if a serious issue effect occurs after hours, on a holiday, or during the weekend, that I should immediately seek Emergency assistance from the nearest hospital.
10. Prescription dosage(s) have been thoroughly explained to me by my physician and I understand that I **SHALL NOT** change dosage amounts of alter the time schedule of the prescribed medication without directions to do so by my physician.
11. I understand that narcotic medication(s) should be kept in a safe place at all times and that I am responsible for the security of my medications. It has been thoroughly explained to me that the policy does not allow for replacement of misplaced, spilled, inaccessible, or lost narcotic medication(s) or prescription(s). I understand that if my medication(s) or prescription(s) are stolen that I must deliver a police report to my physician and they will contact the police department for verification of the report. A second event such as above may lead to termination of this contract.
12. I must keep all appointments as recommended by my physician.
13. I understand the benefits of narcotic medications will be evaluated regularly using the following criteria:
14. Increase in general level of functioning
15. Increase in life activities
16. Decrease in the intensity of pain
17. Absence of unacceptable or intolerable adverse effects
18. Improvement in mood
19. I agree to participate in psychotherapy sessions and psychological testing as deemed appropriate by my physician and/or the team of health care provider(s).
20. I agree to submit to random urine and/or blood screens for other medications and drugs.
21. I have been given information about the use of narcotic medication, including possible risks and adverse side effects such as the development of tolerance, dependence, addiction, and withdrawal and after thoroughly reviewing the information; I believe the benefits will be greater than the risks.
22. I will not hoard narcotic medication.
23. I will not alter the narcotic prescription.
24. I will not drink alcohol within 24-48 hours of taking narcotic medication(s).
25. I understand that violations to this agreement may result in the termination of controlled substances as part of my treatment plan.
26. I agree to allow Edward Rubin, MD to contact other pharmacies to discuss my medications.
27. I understand Edward Rubin, MD /healthcare team has an obligation to check my name in the NYS database (Istop) with each opioid prescription.

### **Narcotic Treatment Monitoring**

During this period, I understand that I might have my narcotic medication discontinued at any time for any reason, per a decision by my physician and the health care team. If notified of such discontinuance, I will be provided with a 30 day supply of an appropriate medication(s). I further understand that during this period I could be referred to an addiction specialist or to a drug detoxification program if warranted. In cases requiring admission to an inpatient detoxification program, NO further medication will be provided.

I attest to the following **(initial below)**:

\_\_\_ I am not using illegal drugs or prescription drugs prescribed for someone other than myself

\_\_\_ I am not undergoing treatment for substance (drugs or alcohol) dependence or abuse.

\_\_\_ I have never been involved in the sale, illegal possession, or transport of drugs.

\_\_\_ I have read this document or had it read to me and, I understand the possible side effects and complications of narcotic therapy.

**FEMALES ONLY (initial below):**

\_\_\_ I am not pregnant. I will inform the medical staff if I become pregnant or intend to become pregnant. I understand that there may be harmful effects on an unborn infant if I take narcotic medication(s).

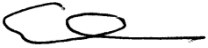
**Release**

I release my physician, the team of health care providers, and Edward Rubin, MD, from liability for any social consequences related to narcotic medication(s) therapy and/or discontinuance of narcotic medication(s). This includes but is not limited to job related issues, legal issues, DMV action and relationship issues.

**Acknowledgement/Agreement**

I hereby acknowledge that the content of this contract has been explained to me. I was offered an opportunity to ask questions and discuss any unclear aspects of this contract. I acknowledge that I fully understand that my failure to comply with any term(s) set forth within this agreement will result in termination of this contract and of my care and medications at our center.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature:  \_\_\_\_\_ Date: \_\_\_\_\_