

Patient name:  
Patient DOB:  
MRN:

Sickle Cell Center/Infusion Center for Adults at Johns Hopkins  
Contract for Controlled Substances Prescriptions in the Management of Chronic Pain

My sickle cell provider and I agree that a controlled substance is a necessary part of the treatment for my sickle cell disease. I understand that narcotic medication is only one part of the overall treatment plan and I agree to participate in all recommended treatments and follow-up.

#### RISKS

1. I am aware that this medication has a potential for addiction, abuse and/or dangerous consequences, including death if taken improperly.
2. I have been informed of the specific risks and side effect of my medication including:  
? {MISC; Medication Risks:22166}

{Blank single:19197::"3. I understand that if I become pregnant while taking this medication, my baby may be born dependent on the medication and other risks to the child may exist." " "}

#### CONDITIONS

1. I will take the following medications as prescribed: \*\*\*
2. I will not get prescriptions for this or any similar (narcotic) medication from anywhere except the Sickle Cell Center/Infusion Center.
3. I will not go to any other emergency room other than Johns Hopkins unless I am taken there by ambulance.
4. If I am seen in an emergency room or get hospitalized, I will not ask for a prescriptions from that staff on discharge unless I am completely out of medication and my sickle cell provider is unavailable. Should this occur, I will notify the sickle cell clinic as soon as possible that I have obtained a prescriptions from another provider.
5. I will only use the pharmacy listed in EPIC to fill these prescriptions and that will be:  
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6. I have fully informed my sickle cell provider of any current or prior use of alcohol, medications and/or illegal drugs.

7. I will not use abuse alcohol or use any illegal drugs while taking this medication. I agree to let my sickle cell provider check my urine or blood at any time for alcohol or drugs.
8. I will not sell these medications or share them with anyone.
9. I understand that prescriptions may not be refilled before they are due even if lost or stolen. In some instances, if lost or stolen, I may be ask to provide a police report. It is my responsibility to keep track of the medication.
10. I am aware that prescriptions will not be provided for more than a one month supply unless my sickle cell provider has discussed a more frequent schedule with me. Refills are not available at nights, on weekends, but instead via the prescription hotline @ 443-287-8288, option #2. I will call at least two days prior to receive my medication. It is my responsibility to obtain prescription refills before they run out.
11. I give the Sickle Cell Center/Infusion Center permission to communicate with any of my other providers about my use of controlled substances.
12. I will refrain from any abusive, threatening and/or inappropriate behavior with Sickle Cell Center/Infusion Center staff or patients.
13. If I develop a painful episode and need additional narcotics I will contact the Sickle Cell Center/Infusion Center prior to increasing my dose.

I understand that if I fail to meet all the agreements of this contract that the Sickle Cell Center/Infusion Center may need to stop prescribing any of these type of medications for me. I also understand that I may need to enter a chemical dependence program to avoid symptoms of withdrawal.

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

\_\_\_\_\_

Sickle Cell Center/Infusion Center Provider: \_\_\_\_\_ Date:

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