REGENERATIVE
INSTITUTE OF NEWPORT BEACH

1601 Dove Street, Suite 275
Newport Beach, CA 92660
(949) 438-1888 (949) 200-6909
www.orthorepair.com

PAIN MANAGEMENT GUIDELINES AND CONTRACT

In order to ensure optimal patient care and safety the following guidelines will be instituted for narcotic pain medication usage and prescriptions.

The physicians at the Regenerative Institute of Newport Beach committed to delivering excellent orthopaedic and pain management care for our patients. As a physicians and surgeons we understand the necessity for pain medications prior to and following a surgical procedure. Many of these medications are often narcotics which may cause short, as well as long term side effects. Long term use of theses medications can be deleterious to your health.

Post-operative narcotic pain medication will be prescribed for a pre-determined period of time consistent with the type of procedure preformed. It is unlikely medication will be prescribed longer than 12 weeks, but it will be up to your physician to make the ultimate determination. Please discuss your medication needs with your physician prior to surgery. I, _____, understand that compliance with the following guidelines is important to the continuation of pain treatment by Dr. Khyber Zaffarkhan, D.O.

1. I will take medications at the dose and frequency prescribed. No other pain medications are to be taken unless discussed first with Dr. Khyber Zaffarkhan, D.O.
2. I will comply with my scheduled appointments.
3. No pain medication will be refilled by phone. I understand that pain medication prescriptions **will only be refilled at the scheduled clinic appointments. If you request an early refill (i.e. going out of town) you must return to the office and complete a medical exception form.**
4. I will not request or receive controlled-substances or any other pain medicine from prescribers other than Dr. Khyber Zaffarkhan, D.O.
5. I will consent to random drug testing.
6. I will protect my prescribed medications. No lost or stolen medications will be replaced.
7. I will inform all my physicians of pain treatments through and/or from Dr. Khyber Zaffarkhan, D.O.
8. I agree to participate in psychiatric, neuropsychology and substance abuse assessments. If Dr. Khyber Zaffarkhan, D.O feels it necessary.
9. This agreement will be placed in my medical record.
10. I understand that if I have any questions or concerns regarding my pain management medication treatment that I will call Rosie or Tanya at Dr. Zaffarkhan's office.
11. The use of multiple pharmacies to fill narcotic medication will result in denial of further medication and immediate discharge from our practice.
12. There will be **NO** medication refills **after hours** or **on the weekends**.
13. ***You will be required to take an initial and a yearly drug screening test. In addition, a randomized screening test as the doctor feels necessary.***

I have read and understand the above guidelines and have received a copy. Initial: _____

Pharmacy: _____ Phone: _____

_____	_____	_____
Patient's Printed Name	Patient's Signature	Date
_____	_____	_____
Medical Record Number	Physician's Signature	Date

REV 04.27.2016