JACK W. TUBBS, JR., M.D.

ASSOCIATES IN OBSTETRICS & GYNECOLOGY

DIANE LINK, RNC, NP
LASTENIA RYAN, MSN, WHNP-BC

NARCOTICS/RESTRICTED MEDICATIONS CONTRACT

I, _____ DOB ____/____/____

Do agree that all of my narcotics/restricted medications will be used for the purpose that they were prescribed for and will only be used by me. I will call during normal weekday business hours for any needed refills. I will not be allowed any early refills for lost narcotics/restricted medications or lost scripts for the same.

I will have all of my narcotics/restricted medications refilled through this office.

I will notify my physician or my pain specialist if my pain is being inadequately treated. An increase in the narcotic/restricted medications will be made if these doctors believe that this will help control my pain. All of the new prescriptions will be made out through this office, even if it is recommended by my pain specialist. I will have my pain specialist notify my physician if increases are warranted.

I will follow the above mentioned statements in order to continue to receive my narcotic/ restricted medications here. If I show evidence of misuse, abuse, or lying about my narcotic/ restricted medications use, to include receiving medications from other physicians, I understand that this will be grounds for stopping any further refills and/or dismissal from this practice.

_____ ____/____/____
Signature of patient/guardian Date

_____ ____/____/____
Signature of Physician Date

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