Practice:_____ Address:_____ Phone: _____ Email:_____

Provider/Practice and Patient Contract for using Opioid Pain Medication in Chronic Pain

This is an agreement between _____ (the patient) and _____ (provider name and credentials) concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of a chronic pain problem. The medication may not completely eliminate my pain but is expected to reduce it enough that I may become more functional and improve my quality of life.

1. I understand that opioid analgesics are strong medications for pain relief and have been informed of the risks and side effects involved with taking them.
2. I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hour of the last dose. I understand that opioid withdrawal is quite uncomfortable, but not a life-threatening condition.
3. I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids and withdrawal can be life-threatening for a baby.
4. Overdose on this medication may cause death by stopping my breathing; this can be reversed by emergency medical personnel if they know I have taken narcotic pain-killers. It is suggested that I wear a medical alert bracelet or necklace that contains this information.
5. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.
6. I understand it is my responsibility to inform the provider of any and all side effects I have from this medication.
7. I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing provider. Running out early, needing early refills, escalating doses without permission, and losing prescriptions may be signs of misuse of the medication and may be reasons for the provider to discontinue prescribing to me.
8. I agree that the opioids will be prescribed by only <u>one</u> provider and I agree to fill my prescriptions at only <u>one</u> pharmacy. I agree not to take any pain medication or mind-altering medication prescribed by any other provider(s) without first discussing it with the provider named above. I give permission for the provider to verify that I am not seeing other provider(s) for opioid medication or going to other pharmacies.
9. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced.
10. I agree not to sell, lend, or in any way give my medication to any other person.
11. I agree not to drink alcohol or take other mood-altering drugs while I am taking opioid analgesic medication. I agree to submit a urine specimen at any time the provider requests and give my permission for it to be tested for alcohol and drugs.

12. I agree that I will attend all required follow-up visits with the provider to monitor this medication and I understand that failure to do so will result in discontinuation of this treatment. I agree to participate in other chronic pain treatment modalities if recommended by my provider.
13. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with a history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.

I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the doctor may discontinue this form of treatment.

_____ _____

Patient Signature Date

_____ _____

Provider Signature Date

I understand that the medication is prescribed as follows:

Type of medication: _____

Number of pills and frequency: _____

Total number of pills: _____ Next refill due: _____

_____ _____

Patient Signature Date

_____ _____

Provider Signature Date