**OPIOID MEDICATION MANAGEMENT AGREEMENT**

*This sample pain management agreement is intended as a reference document. Consult your local state laws to adapt this document for your own use.*

Opioids are substances that act on the nervous system. One of their primary functions is the treatment of pain. Due to the chemical make-up of these medications, they may have adverse effects which are important to recognize. They may cause drowsiness that can be worsened by other drugs such as benzodiazepines, other sedating medications, and even alcohol. These medications are not suggested for use while driving and or operating machinery. Other common side effects include nausea, itching, sleep apnea, and constipation. Overdose of opioids can cause severe side effects, even death. It is impossible to predict opioid side effects in any individual patient. The development of addiction is possible with these medications. Keep in mind, side effects with one opiate does not necessarily mean you will have side effects from another.

You must take opioids only as directed by your doctor. Federal laws prohibit sharing or selling this medication to anyone else. Physical dependence may occur but does not, by itself, indicate an addiction. Withdrawal syndrome may develop if you stop your medication abruptly. In addition, tolerance may develop to the pain relief effects from this class of drug.

Some types of pain will not respond to opioids, or there may be a partial response to opioid therapy. The need for increased dosing may indicate the medication is no longer effective (tolerance), possible psychological dependence, or addiction. In some instances, the use of opioids can make your pain worse. Discontinuing opioid medications under these circumstances may be suggested.

The purpose of this Agreement is to prevent misunderstandings about opioids you will be taking for pain management. This overview is to help both you and your doctor follow laws and regulations regarding controlled pharmaceuticals.

\_\_\_ I understand that my physician has determined that, in my case, the benefits of taking the medication outweigh the risks. I understand that controlled prescription medications have significant risks and those risks have been discussed with me prior to taking the prescribed medication. I understand that an improvement in my quality of life and an improvement in my functional status is one of the goals of taking the prescribed medication. I realize that all medications have potential side effects, and that if I begin to experience side effects, I will bring those to the attention of the prescribing physician.

\_\_\_ I understand only my pain doctor will prescribe opioid medications for me and I will not attempt to obtain any controlled medicines, including opioid medicines, controlled stimulants or antianxiety medicines from any other doctor. I will only utilize one pharmacy to obtain my opioid medications. While I am taking opioid medications I will not use any illegal substances, including, but not limited to, marijuana, or products made from marijuana.

\_\_\_ I agree to keep all scheduled appointments with any healthcare professional in collaboration with this agreement. [*Number of missed appointments*] missed appointments or cancellations for same day appointments may result in the discontinuation of my opioid prescription or dismissal from the practice. I understand that my prescriber may check the prescription drug monitoring program available in my state, or surrounding states, on a regular basis to ensure that I am not receiving additional opioids, or other medications of abuse, from other providers.

\_\_\_ I agree to regular or unannounced drug screenings. I understand any positive or inconsistent results for any illegal substances, or the presence of legal substances for which I do not have an active prescription, will result in my dismissal.

\_\_\_ I agree that there are no early refills for lost, destroyed, or stolen medication. I will be responsible for my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.

\_\_\_ Prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours.

\_\_\_I understand that I am expected to inform our office of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.

\_\_\_ I agree to fully comply with all aspects of my treatment program including behavioral medicine and physical therapy, if recommended. Failure to do so may lead to discontinuation of my medication and referral(s) to an outside physician will be warranted. In this case, my doctor will taper the medicine down over a period of several days to avoid withdrawal symptoms.

\_\_\_ I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

\_\_\_ I will bring all unused pain medicine to every office visit.

\_\_\_ I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state’s Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

\_\_\_All of my questions and concerns regarding treatment have been adequately answered.

\_\_\_I give permission to my pain doctor to contact my other healthcare providers, for the purpose of sharing information concerning my situation, as is deemed necessary for coordinated, high quality care.

I, the undersigned, agree to follow these guidelines that have been fully explained to me.

This Agreement is entered into on this \_\_\_\_\_\_\_ day of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_.

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_

Witnessed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_