

Patient Agreement for Long-Term Opioid Therapy

1. I, _____ agree that Dr. _____ will be the only physician prescribing OPIOID (also known as NARCOTIC) pain medication for me and that I will obtain all of my prescriptions for opioids at one pharmacy location. The exception would be an emergency situation or in the unlikely event that I run out of medication. Should such occasions occur, I will inform my physician as soon as possible.

1. I will take the medication at the dose and frequency prescribed by my physician. I agree not to increase the dose of opioid without first discussing it with my physician. I will not request earlier prescription refills.

2. I will attend all reasonable appointments, treatments, and consultations as requested by my physician. I agree to other pain consultations/management strategies as necessary.

3. I understand that the common side effects of opioids therapy include nausea, constipation, sweating and itchiness of the skin. Drowsiness may occur when starting opioid therapy or when increasing the dosage. I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness disappears.

4. I understand that using long-term opioids to treat chronic pain may result in the development of a physical dependence on this medication, and that sudden decreases or discontinuation if the medication will lead to the symptoms of opioid withdrawal. I understand that opioid withdrawal is uncomfortable but not life threatening.

5. I understand that there is a small risk that I may become addicted to the opioids I am being prescribed. As such, my physician may require that I have blood, urine or hair testing and/or see a specialist in addiction medicine should a concern about addiction arise.

6. I understand that the use of a mood-modifying substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore I agree to refrain from the use of all these substances without prior agreement from my physician.

7. I understand that I should check with my physician or pharmacist before taking other medications including over-the-counter and herbal products.

8. I agree to be responsible for the secure storage of my medication at all times. I agree not to give or sell my prescribed medication to any other person. Depending on the circumstances, lost medication may not be replaced until the next renewal date.

9. I consent to open communication between my doctor and any other health care professionals involved in my pain management, such as pharmacists, other doctors, emergency departments, etc.

10. I understand that if I break this agreement, my physician reserves the right to stop prescribing opioid medications for me.

Date: _____

Signature – Patient

Signature - Physician