Pain Agreement

Section I

Introduction

I, _____, am seeking healthcare services for the treatment of my painful condition from the _____. I understand treating my condition will require a plan/program involving medication therapy for pain management. There are numerous state and Federal laws and regulations regarding the use of prescription medications and specifically controlled substances such as opioids. The purpose of this agreement is to help this healthcare practice and I comply with these laws and regulations. I understand this agreement will provide me with information about my treatment plan, and the medications I am prescribed to alleviate my pain to help me understand my pain.

_____ (initials)

Goals of Therapy

The purpose of this agreement is to provide me with information about the medications I will be taking for pain management and to assure I and my physician comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy may be considered for moderate to severe pain with the intent of reducing pain and increasing function. The provider's goal is for me to have the best quality of life possible given the reality of my clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

_____ (initials)

Section II

Patient Disclosure of Current Medications and History of Substance Abuse

Current Medications

I will inform my physician of all medications I am taking, since opioid medications can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine or hydrocodone. I understand the use of alcohol and opioid medications is not advised.

_____ (initials)

History of Substance Abuse

I do not currently have problems with substance abuse (drugs and/or alcohol).

_____ (initials)

I will not use illegal or street drugs or alcohol. My provider may ask me to follow through with a program to address my substance abuse issue. Such programs may include the following:

- 12-step program and securing a sponsor
- Chemical Dependency evaluation
- Individual counseling
- Inpatient or outpatient treatment
- Other: _____ _____ (initials)

Section III

Definition of a Single Provider and Single Pharmacy

I will receive opioid medication prescriptions only from the _____. I will not receive opioid medications from any other source. I agree to notify my provider in advance of any anticipated acute needs (e.g., dental work or surgery) which may require a change in my opioid dose.

_____ (initials)

I will not attempt to obtain any controlled medicines, including opioid pain medications, or controlled stimulants, from any other provider.

_____ (initials)

I agree to only use my medications as prescribed and for the purpose prescribed and that if I overuse my medications they will not be refilled early.

_____ (initials)

I agree to use_____ Pharmacy, located

at _____, telephone

number_____, for filling prescriptions for all my pain

medications.

_____ (initials)

If I receive opioid medications from another provider while a patient with the _____, I will be dismissed from the practice.

_____ (initials)

Section IV

Information Consent on the Risk of Using Opioids

Possible Side Effects of Opioids

- Confusion or other change in thinking abilities
    - Problems with coordination or balance which may make it unsafe to operate dangerous equipment or motor vehicles. If you believe you are impaired you SHOULD NOT operate dangerous equipment or a motorized vehicle
    - Breathing too slowly – overdose can stop your breathing and lead to death
    - Nausea
    - Sleepiness or drowsiness
    - Vomiting
    - Constipation
    - Aggravation of depression
    - Dry mouth

Other side effects may include, but are not limited to, the following: unsteadiness, decreased appetite, problems urinating, depression and sexual dysfunction (in males, testicular atrophy). **These side effects may be made worse if I mix opioids with other drugs, including alcohol.**

_____ (initials)

Section V

Definition of Addiction, Tolerance and Physical Dependence

Addiction, Tolerance and/or physical dependence can occur with the use of opioid medications.

Addiction is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life.

Tolerance means a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time. The does of the opioid may have to be titrated up or down to a dose that produces maximum function and a *realistic* decrease of the patient's pain.

Physical dependence means if the opioid medication is abruptly stopped or not taken as directed, a withdrawal symptom may occur. This is a normal physiological response. The withdrawal syndrome could include, but are not limited to: sweating, nervousness, abdominal cramps, diarrhea, goose bumps and alterations in one's mood.

_____ (initials)

Section VI

Self-report on Pain, Side Effects, and Function at Follow-up Visits

I will communicate fully with my provider about the character and intensity of my pain, the effect of pain on my daily life and how well the medicine is helping to relieve my pain.

_____ (initials)

Pregnancy (Female Patients Only)

I understand the potential harm of opioid medication to unborn children and agree to notify the _____ if I am or become pregnant in the future.

_____ (initials)

Establishment of Regular Follow-up Care Visits and Medication Refills

Changes in my prescriptions, including dose adjustments, refills, and new medications, **will be made only during scheduled office visits and not over the phone or during unscheduled visits**. Telephone calls regarding opioid medication should be limited to reports of significant side effects necessitating decreasing or stopping the medication.

_____ (initials)

Prescription Refill Requirements

Prescription refill requests must be submitted to your pharmacy **14 days prior** to the refill date. Please note - all prescription requests will be processed during regular office hours only. **NO refills** of any medications will be completed during the evening hours or on weekends.

_____ (initials)

Consent to Unannounced Urine Drug Screen Tests or Pill/Patch/Stick Counts

I understand I will consent to unannounced drug screening. A drug screen is a laboratory test in which a sample of my urine or blood is checked to determine what drugs I have been taking.

_____ (initials)

I may be asked to bring all unused pain medications, in their original containers, to my office visit. I will comply when requested to bring my pain medications to my appointment.

_____ (initials)

I may be asked to comply with a request for an unannounced pill/patch/stick count.

_____ (initials)

Section VII

Definition of Terms of Non-compliance and Termination of Treatment

Evidence of misuse/abuse of opioids will result in tapering and discontinuation. Specific examples of misuse/abuse include injecting or snorting oral formulations; selling, giving away, or borrowing opioids; and frequent dosage escalations despite warnings.

Other unacceptable activities include prescription forgery; obtaining drugs from non-medical sources; concurrent use of alcohol or illicit substances; repeatedly seeking prescriptions from other clinicians or emergency room departments; deterioration in functioning at work, in the family, or socially; and repeated resistance to changes in therapy despite clear evidence of physical or psychological side effects.

I understand my failure to meet these requirements may result in my provider choosing to stop prescribing opioid medications for me. Withdrawal from the medications will be coordinated by the provider and may require specialist referrals.

_____ (initials)

Section VIII

Missed Appointments

If I consistently fail to keep scheduled appointments without 24 hours advance notification, I will be subject to dismissal from the practice (three or more missed appointments in one (1) year whether no shows, cancellations or a combination of both).

_____ (initials)

Lost or Stolen Prescriptions

I understand I am receiving medications which are at high risk of being stolen. I am responsible for protecting these medications. The _____ cannot replace medications or prescriptions which are lost or stolen. I also understand if my medications are stolen, I am required to file a report with local law enforcement agencies.

_____ (initials)

Use of Illegal Controlled Substances

I will not use any illicit substance, such as cocaine, marijuana, etc. while a patient of the _____. A positive urine drug screen may result in termination of my opioid therapy and a mandatory chemical dependency evaluation.

_____ (initials)

The position of the _____does not allow the prescribing of opioid medications to any patient who is a user of medical marijuana. If you use medical marijuana, for any reason, you will not receive any opioid

medications and will be required to titrate off the medical marijuana to continue to receive opioid medications.

_____ (initials)

Sharing, Selling or Trading Medications

I understand selling, trading or giving medication **prescribed to me** to another person, including a family member, is illegal.

_____ (initials)

Section IX

Patient Waiver of Privacy

I authorize my provider and my pharmacy to cooperate fully with any city, state or Federal law enforcement agency, including the state of residency's state Board of Pharmacy, in the investigation of possible misuse, sale or diversion of my pain medication. I authorize my provider 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.

_____ (initials)

Section X

Required Signatures

I affirm I have full right and power to sign and be bound by this agreement and that I have read, understand and accept all of its terms. I understand violations of this pain agreement may result in dismissal from the _____.

I have read this document, understand it, and have had all my questions answered satisfactorily. I agree to the use opioids to help control my pain. I understand my treatment with opioid medications will be carried out in accordance with the conditions stated above.

I certify I have knowingly and willingly signed this contract.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

_____ _____
Provider Signature Date