OPIOID TREATMENT AGREEMENT

Patient Name: ___________________________________ Claim No.______________________________

Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist in your return to work effort.
I, _______________________________, understand that compliance with the following guidelines is important in continuing pain treatment with Dr. _____________________.

1. I understand that I have the following responsibilities:
a. I will take medications only at the dose and frequency prescribed.
b. I will not increase or change medications without the approval of this provider.
c. I will actively participate in Return to Work (RTW) efforts and in any program designed to improve function (including social, physical, psychological and daily or work activities).
d. I will not request opioids or any other pain medicine from providers other than from this one. This provider will approve or prescribe all other mind and mood altering drugs.
e. I will inform this provider of all other medications that I am taking.
f. I will obtain all medications from one pharmacy, when possible. By signing this agreement, I give consent to this provider to talk with the pharmacist.
g. I will protect my prescriptions and medications. Only one lost prescription or medication will be replaced in a single calendar year. I will keep all medications from children.
h. I agree to participate in psychiatric or psychological assessments, if necessary.
i. If I have an addiction problem, I will not use illegal or street drugs or alcohol. This provider may ask me to follow through with a program to address this issue. Such programs may include the following:
12-step program and securing a sponsor
Individual counseling
Inpatient or outpatient treatment
Other: __________________

2. I understand that in the event of an emergency, this provider should be contacted and the problem will be discussed with the emergency room or other treating provider. I am responsible for signing a consent to request record transfer to this doctor. No more than 3 days of medications may be prescribed by the emergency room or other provider without this provider's approval.

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

4. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.

5. I understand that this provider may stop prescribing opioids or change the treatment plan if:
a. I do not show any improvement in pain from opioids or my physical activity has not improved.
b. My behavior is inconsistent with the responsibilities outlined in #1 above.
c. I give, sell or misuse the opioid medications.
d. I develop rapid tolerance or loss of improvement from the treatment.
e. I obtain opioids from other than this provider.
f. I refuse to cooperate when asked to get a drug screen.
g. If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.
h. If I am unable to keep follow-up appointments.

Patient Signature ____ Date ________________________

Provider Signature _______________________________________ Date ________________________

Source: AMDG 2010 Opioid Dosing Guideline