Pain Management Medication Agreement

- The purpose of this agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This is to help both you and your doctor comply with the law regarding controlled pharmaceuticals. I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement. I understand that if I break this agreement, my doctor will stop prescribing pain control medications. In the case, my doctor will taper off the medication over a period of several days (not to exceed two weeks), as necessary, to avoid withdrawal symptoms. Also, a drug dependence treatment protocol may be recommended.

- I am aware that the use of such medication has certain risks associated with it, including but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, decrease in respiration rate, physical dependence, tolerance to analgesia, addiction and possibly that the medication will not provide complete relief.

- I will tell my doctor about all other medication and treatments that I am receiving. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might be slowed. Such activities include, but are not limited to: using heavy equipment in a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for them self.

- I am aware that addiction is deemed as the use of a medication even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medication is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor and counselor my complete and honest personal drug history and that of my family to the best of my knowledge.

- I understand that physical dependence is a normal, expected result of using these medications for an extended period of time. I understand that physical dependence is not the same as addiction. I am aware that tolerance to analgesia means that I may require more medication to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has occurred and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

- I will communicate full with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to relieve the pain.

- I WILL NOT USE ANY ILLEGAL CONTROLLED SUBSTANCES, INCLUDING MARIJUANA, COCAINE, etc. I WILL NOT SHARE, SELL OR TRADE MY MEDICATION TO ANYONE.

- I WILL NOT ATTEMPT TO OBTAIN ANY CONTROLLED MEDICATIONS, INCLUDING OPIOID PAIN MEDICATION, CONTROLLED STIMULANTS, OR ANTI-ANXIETY MEDICATIONS FROM ANY OTHER DOCTOR. (Anti-anxiety medications may be obtained following discussion between this office and the prescribing doctor.)

- I WILL SAFEGUARD MY PAIN MEDICATION FROM LOSS OR THEFT. LOST OR STOLEN MEDICATIONS WILL NOT BE REPLACED. I realize that lost, discarded or stolen medication is a breach of the medication agreement.
• I agree that refills of my prescriptions for pain medication will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.
• I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the state’s Board of Pharmacy, in the investigation of a possible misuse, sale, or other diversion of my pain medication. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privileges or right of privacy or confidentially with respect to these authorizations.
• I agree to use one pharmacy for my prescriptions____________________________________________
• I understand and agree that I will submit to blood and/or witnessed urine testing as requested by my doctor to access any symptom that I present and determine my compliance with my prescribed program of long term use of pain medications to control my chronic pain condition. This includes HIV and other esoteric testing as deemed necessary.
• I will bring in my medications for a pill count when requested to do so by my doctor or representative.
• I agree that I will use my medication at a rate no greater than the prescribed amount and that use of my medication at a greater rate will result in my being without medication for a period of time.
• I understand the treatment of pain requires a multimodality approach and that the best outcomes cannot be obtained solely on pain medications alone. I agree to participate entirely with the prescribed treatment plan as determined by my doctor to include: counseling (individual and group), physical therapy, and interventional procedures.
• I understand that chronic pain impacts the quality of life and is most always accompanied by depression. I agree that in order for me to have the best quality of life, the areas that chronic pain impacts physical and mental must be addressed. I understand and agree to participate with the counselor/therapist as my doctor determines is necessary.
• I understand that my failure to cooperate with the treatment plan as established by my doctor and team that I will be in breach of the agreement and can be DISCHARGED from care.
• MALES ONLY: I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my moods, stamina, and sexual desire, physical and sexual performance. I understand that my doctor may check blood to determine if my testosterone level is normal.
• FEMALES ONLY: If I plan to become pregnant or believe that I have become pregnant while taking the prescribed pain medication, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to deliver while taking these medications, the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medications and there always the possibility that my child will have birth defects while I am taking an opioid.

I agree to the following guidelines that have been explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on the Date:_________________________

Patient Name:____________________________ Patient Signature:________________________________

Physician Signature:_____________________________ Witnessed by:_____________________________