1. Doctor and Patient. I, _____, agree that Dr._____ will be the only doctor(s) who will prescribe the OPIOID medication_____. I will not obtain opioid medication from another doctor. If this happens, I will tell Dr._____ as soon as possible.

2. Treatment Expectations and Goals. This medication is being used to decrease the severity of my chronic pain and improve my ability to function physically, emotionally, socially and at work. At best, opioid medication may reduce my chronic pain by about 30% but will not completely stop my chronic pain. Because of the limit to which it will decrease my pain, the best evidence of success from this medication is how well it improves my function. My goals for increasing my function are _____

_____.
I understand that if the opioid treatment does not improve my pain control or my ability to function then it will be reduced and stopped.

3. Take as Prescribed. I will take the medication at the dose and frequency ordered by my doctor. I know it is important to take this medication at regular times and not only "when needed". I will not increase the dose of my opioid medication on my own and am aware that doing so may lead to this treatment being stopped. Only a small supply of extra doses may be prescribed each month for the treatment of flare-ups of my pain. I agree to record regularly my use of these opioid medications and how they are working.

4. Side Effects. I understand that the common side effects of opioid medication include feeling sick (nausea), vomiting, constipation, drowsiness, dry mouth, and itchiness of the skin. With extended use I am likely to become tolerant to these side effects, except for constipation. Constipation is a very common side effect and I may be ordered medication to help with this problem. Other side effects which are rare include muscle jerks or shaking, muscle spasm, feeling weak, confusion, hallucinations, feeling disoriented, chills, changes in vision, difficulty passing urine, headaches, skin rashes, difficulty in thinking clearly, decreased sexual function, swelling of hands or feet, sweating, and decreased immune function.

5. Driving. There is a risk I may become drowsy when starting opioid therapy or when the dose is increased. I agree not to drive a motor vehicle or operate dangerous machinery until I am on a stable dose and do not experience any drowsiness.

6. Use with Other Medications. I also understand that I may become very drowsy if I take opioid medication at the same time with other medications that cause drowsiness (such as sedatives or sleeping pills) or with alcohol. I will not take any of these without talking to my doctor first.

7. Medication Complications. I understand that opioids may cause long-term complications, which may include decreased hormones such as testosterone, unexpected increase in pain sensitivity, and changes in breathing patterns while sleeping.

8. Addiction. I am aware that there is a small risk that I may become addicted to the prescribed opioids. I know that my doctor may order a consultation with a specialist in Addiction Medicine if there is a concern about addiction.

9. Adherence. I understand that my doctor may ask me for a urine drug screen sample or a count of my pills at any time. This is performed routinely for all patients to improve the overall safety of using opioids. Urine drug monitoring will also look for other substance use that increases the risks associated with using opioids. Further refills/prescriptions will be tied to completion of urine tests.

10. Use of Other Medications. I will not use non-prescription medications containing codeine, such as Tylenol ® #1 or 222® Tablets. My doctor may request me to reduce the dose of medications (such as sleeping pills) that increase my risk of harm when used in combination with an opioid.

11. Stopping Medications and Withdrawal Symptoms. I understand that suddenly stopping or reducing the amount of opioid that I am taking may lead to withdrawal symptoms. Initial symptoms may include runny nose, sweating, tearing of the eyes, restlessness and/or diarrhea. Later symptoms may include anxiety, irritability, weakness, twitching and muscle spasms, severe backache and abdominal pain, leg pains and cramps, hot and cold flashes, sleeplessness, nausea, vomiting, slight fever, increased heart rate and blood pressure. These symptoms can be minimized by slowly reducing the opioid dose and should only be done under the direction of my doctor. If I have stopped taking my opioid medication for 3 days or more for any reason I will not resume taking it without talking to my doctor.

12. Appointment Attendance. I will attend all appointments, treatments and consultations as requested by my doctor.

13. Running Out of Medication. I will plan and book appointments well in advance. I understand that if my prescription runs out early for any reason (such as if I lose the medication, take more than prescribed or miss an appointment) I will not be prescribed extra medications. I will have to wait until my next prescription is due.

14. Switching to a Different Opioid. I agree that my doctor may switch me to a different opioid medication in the future. If this happens I will return the remaining quantity of my opioid medication to my pharmacy for safe disposal. I will continue to follow the terms of this agreement for my new opioid medication.

15. Safe Storage and Security. I agree to be responsible for the secure storage of my medication at all times. I agree not to give or sell my prescribed opioid medication to any other person; nor will I accept any opioid medication from anyone else. I will keep the medication in a safe and secure place out of reach of children.

16. One Pharmacy. I will fill my prescriptions at one pharmacy of my choice, which will be _____.

17. Consent to Share Information. I agree that my doctor has the authority to share prescribing information in my patient file with other health care professionals (including community pharmacists) when medically necessary.

18. Breaking This Agreement. If I break any part of this agreement I understand my doctor has the right to stop prescribing opioid medications for me.

THIS AGREEMENT MADE THE _____DAY OF_____, 20____.

_____ _____

Patient Signature **Prescriber Signature**

_____ _____

Patient Name Printed **Prescriber Name Printed**

Review Date:

This contract was revisited on this _____day of _____, 20____.

_____ _____

Patient Signature **Prescriber Signature**

This contract was revisited on this _____day of _____, 20____.

_____ _____

Patient Signature **Prescriber Signature**

This contract was revisited on this _____day of _____, 20____.

_____ _____

Patient Signature **Prescriber Signature**