Pain Treatment Agreement

An agreement between you and your doctor for the long-term treatment of chronic pain

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**. 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.

2. 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 early prescription refills.

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

4. I understand that the common side effects of opioid 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.

5. 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 of the medication will lead to the symptoms of **opioid withdrawal**. I understand that opioid withdrawal is uncomfortable but not life threatening.

6. 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.

7. 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 of these substances without prior agreement from my physician.

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

9. 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 regular renewal date.

10. 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.

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

SIGNATURE

Patient's Signature

SIGNATURE

Physician's Signature

DATE

Date

...And make sure to watch Dr. Mike Evan's "Best Advice for People Taking Opioid Medications":
http://objectivehealth.ca/r/opioids

Adapted from rxfiles.ca. A PDF copy of this agreement is available at http://objectivehealth.ca.