Place institution logo and name here.

AGREEMENT TO USE PAIN MEDICINE FOR THE LONG TERM

Please print clearly.

Patient: _____ Provider: _____

Record #: _____ Date: _____

The reason for this agreement is to understand:

- the rules for getting and taking pain medicine;
- what I am expected to do; and
- what will happen if I do not follow these rules.

When I sign this agreement, I am saying that I understand what has been written. I also agree to follow these written rules while I am taking pain medicine.

Treatment Plan

I understand that everybody must follow a treatment plan. I agree to help make my treatment plan and follow it. This will help me build trust with the health care team, and I will have less pain.

I agree to take part in the whole program. I understand that good health habits will help lessen my pain. I understand that I may need to eat a healthier diet, lose weight, or quit smoking. I will also take part in physical or occupational therapy, behavioral health, and other referrals. If I do not fully participate, my pain medicine may be reduced, changed, or stopped.

I understand that my name will be in a registry that shows what pain medicines I am taking. This state registry will be checked from time to time.

Appointments

I agree to keep my appointments and be 15 minutes early. At each appointment, I will fill out the health screening form. If I cannot keep an appointment, I will call the clinic at least 24 hours before my appointment to make another appointment.

I will be honest about my pain when talking with my provider and health care team. I will tell my provider about all and any new medicine I am taking. I will also tell my provider about any changes in my health. I will tell my provider about any problems I have taking the pain medicine.

I will be honest about my alcohol use and will not use alcohol in an unhealthy way. If asked, I will not drink any alcohol while I am on my pain medicine. I understand that alcohol can cause harm or death if it is used with pain medicine.

I agree to bring in all my medicine bottles when I am asked. The health care team will count my pills to help determine whether or not I am following my treatment plan.

I agree to have a urine or blood test on the day it is ordered. This will also help my health care team determine if I am following my treatment plan. I understand that I may not be told of this test before my appointment.

I understand that I can only get my pain medicine when it is due. I can only get my pain medicine during regular clinic and pharmacy hours. My provider may change my pain medicine during an appointment or adjust my plan as needed.

Patient: _____ Provider: _____

Record #: _____ Date: _____

Taking Medicine

I will not take my pain medicine differently from what I have been told to do. If there is evidence that I have done this, my provider and health care team will lessen, change, or stop my pain medicine.

I will not take more pain medicine than I am told to do, even if my pain gets worse. I must talk to my provider or whoever is in his or her place before taking more pain medicine.

I will only get and take pain treatment medications from my treatment team providers. I will only get and take medicine that changes my mood from my treatment team providers. Examples of mood-changing medicine are sedatives, hypnotics, stimulants, anti-anxiety, or anti-depressant medications. I will not get any medicine or drugs by buying them on the street or from any other sources.

I understand that I can die if I take pain medicine differently from what I have been told to do. I must take the right amount of pain medicine at the right time. I may have withdrawals if I am late in taking my pain medicine. I understand that I must re-fill my pain medicine so that I do not miss a dose.

I agree to keep myself and others safe while on pain medicine. I will not drive or operate machinery if I feel sleepy or not of right mind. If this happens, I will use less pain medicine and inform my health care team and provider.

I will not use any illegal drugs. If I have substance use or addiction problems, I will be honest and open with my provider about my use of any legal or illegal, mood-altering substances, drugs, or medications, even if they are legally prescribed.

I will not share, sell, or trade my pain medicine with anyone.

I agree to protect my pain medicine from getting lost or stolen. I understand that lost or stolen pain medicine will not be replaced. I will keep my pain medicine safe—locked up or hidden. I will always keep my pain medicine in appropriately labeled bottles.

I understand that if I do not follow any of the rules I just read, I break this agreement. This means that I may no longer be given narcotic or sedative medications for the treatment of my pain, and my treatment plan will be changed. In some circumstances, this can mean my narcotic prescription will be discontinued.

Signature of Patient: _____ Date: _____

Provider

Explained by me and signed in my presence:

Signature of Provider: _____ Date: _____