Pain Treatment Agreement

I,_____ agree that Dr._____ will be the only physician prescribing opioid pain medication for me. I will not seek opioid medications from other doctors.

I will give written consent for ongoing access to my PharmaNet profile by my doctor as a condition of prescribing. PharmaNet is an important tool in ensuring opioids are used safely.

I will not take opioid medication in larger amounts or more frequently than as prescribed.

I will not give or sell my medication to anyone else, including family members; nor will I accept any opioid medication from anyone else. I agree to be responsible for the secure storage of my medication at all times. I understand that lost or stolen medication may not be replaced.

I will not use over-the-counter codeine containing medications such as 222®'s and Tylenol #1® (codeine compounded with caffeine, ASA or acetaminophen).

I will attend all reasonable appointments, treatments and consultations as requested by my physician.

I understand that the long-term use of opioids to treat chronic pain will often result in 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.

I understand that there is a risk that I may become addicted to the opioids I am being prescribed. My physician may require that I have additional blood or urine testing and/or see a specialist in addiction medicine should a concern about addiction arise during my treatment. I will comply with all requests for laboratory tests including random urine drug screens ordered by my physician.

I understand that the use of any mood altering 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.

I consent to open communication between my doctor and any other health care professionals involved in my pain management, such as pharmacists, other doctors, and emergency departments. This includes reviewing information available from PharmaNet.

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

I will comply with requests by my physician to attend at the office for a pill count between scheduled visits.

Patient's signature: _____

Physician's signature: _____

Date: _____