Patient Agreement for Long-term Opioid Therapy

		Patient Initials
1.	I, _____ agree that the Community Health Centre doctor or nurse practitioner (NP) will be the only doctor or NP prescribing OPIOID (also known as NARCOTIC) pain medication for me.	
2.	I will obtain all of my prescriptions for opioids at one pharmacy. The name of my pharmacy is: _____	
3.	I will take the medication at the dose and frequency prescribed by my doctor or NP. I agree not to increase the dose of opioid without first discussing it with my doctor or NP.	
4.	I will not request early prescription refills.	
5.	I understand that if I lose my medication it will not be replaced until the next regular renewal date.	
6.	I will attend all reasonable appointments, treatments and consultations as requested by my doctor or NP. I agree to other pain consultations/management strategies as necessary.	
7.	I understand that all treatment discussions for my pain management will occur only during health centre hours.	
8.	I agree to pick up my medications during regular health centre hours.	
9.	I understand that the common side effects of opioid therapy include nausea, constipation, dizziness, sweating and itchiness of the skin. Drowsiness may occur when starting opioid therapy or when increasing the dosage. I acknowledge that I have been advised to refrain from driving a motor vehicle (including snowmobiles and ATVs) or operating dangerous machinery until such drowsiness disappears.	
10.	I understand that using opioids may result in the development of a physical dependence, and that suddenly decreasing or stopping the medication will lead to the symptoms of opioid withdrawal. I understand that opioid withdrawal is uncomfortable but not life threatening.	
11.	I understand that there is a risk that I may become addicted to the opioids I am being prescribed. I may have treatment recommended to me should this arise.	
12.	I understand that the use of agents that affect mood, such as sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine or heroin), can cause adverse effects or interfere with opioid therapy. Therefore, I agree to discuss the use of any of these agents with my doctor or NP.	
13.	I agree to give a urine sample for urine testing if asked by my doctor or NP.	
14.	I understand that I should inform my doctor, NP, nurse or pharmacist of any other medications including over-the-counter medication, vitamins and herbal products that I may be taking.	
15.	I agree to be responsible for the secure storage of my medication at all times. I agree not to give or sell my medication to any other person.	
16.	I understand that the Health Centre nurses cannot prescribe opioid medications for me.	
17.	I understand that my care may involve communication between my doctor or NP and other health care professionals involved in my pain management, such as nurses, pharmacists, pharmacies, other doctors, emergency departments, etc.	
18.	I understand that if I break this agreement, my doctor or NP reserves the right to stop prescribing opioid medications for me.	

Date: _____

Patient Signature: _____ Doctor/NP Signature: _____

- ❑ This document has been discussed with and signed by the doctor/NP and patient.
- ❑ A signed copy of this agreement has been placed in the patient's medical chart.
- ❑ A signed copy has been given to the patient.

Adapted from www.PainCare.ca
March 2017