Sample Patient Agreement for Long-term Opioid Therapy

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 earlier 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.

Date: _____

_____ _____

(Signature - Patient) (Signature Physician)