Opioid Medication for Chronic Pain Agreement

Chronic Pain Management Toolkit

This is an agreement between _____ (patient) and Dr. _____.

I am being treated with opioid medication for my chronic pain, which I understand may not completely rid me of my pain, but will decrease it enough that I can be more active. I understand that, because this medication has risks and side effects, my doctor needs to monitor my treatment closely in order to keep me safe. I acknowledge my treatment plan may change over time to meet my functional goals, and that my doctor will discuss the risks of my medicine, the dose, and frequency of the medication, as well as any changes that occur during my treatment. In addition, I agree to the following statements:

Patient Initials	Please read the statements below and initial in the box at the left.
	I understand that the medication may be stopped or changed to an alternative therapy if it does not help me meet my functional goals.
	To reduce risk, I will take medication as prescribed. I will not take more pills or take them more frequently than prescribed.
	I will inform my doctor of all side effects I experience.
	To reduce risk, I will not take sedatives, alcohol, or illegal drugs while taking this medication.
	I will submit to urine and/or blood tests to assist in monitoring my treatment.
	I understand that my doctor or his/her staff may check the state prescription drug database to prevent against overlapping prescriptions.
	I will receive my prescription for this medication only from Dr. _____.
	I will fill this prescription at only one pharmacy. (Fill in pharmacy information below.)
	I will keep my medication in a safe place. I understand if my medicine is lost, damaged, or stolen, it will not be replaced.
	I will do my best to keep all scheduled follow-up appointments. I understand that I may not receive a prescrption refill if I miss my appointment.

Medication name, dose, frequency _____

Pharmacy name _____

Pharmacy phone number _____

By signing below, we agree that we are comfortable with this agreement and our responsibilities.

_____ _____

Patient signature *Date*

_____ _____

Physician signature *Date*