Medford, OR 97504
(541) 773-9772

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Patient Medication Management Agreement for Treatment with Opioids

Patient: _____ MR#:_____

Provider: _____

Condition: _____

Medication: 1. _____

2. _____

3. _____

Goals for taking the medication:

_____

_____

I agree to the following guidelines:

1. I will take this medication as prescribed by my provider. I will not vary the dosage or interval without authorization from my provider.

2. I will submit to random urine or blood tests for drug screens. Positive tests for any illegal substances, or opioid or other narcotic medications not prescribed by my provider, will result in my dismissal and referral elsewhere for substance abuse evaluation and management.

3. I will obtain all my prescriptions through _____ and will fill all prescriptions at _____. In an acute emergency another provider may prescribe medications for me. If this occurs I will notify my primary care provider within 48 hours.

4. I know that I will be unable to obtain early refills or replacement refills of lost, stolen or destroyed medication. Refills will only be made during regular office hours. Requests for refills must be made at least 48 hours in advance to guarantee a timely refill.

5. I agree to keep all scheduled appointments, not just with my provider, but also with recommended therapists and psychological counselors. Three or more missed appointments or same-day cancelations will lead to my dismissal.

6. I agree to fully comply with all aspects of my treatment program for pain management including behavioral medicine (psychology/psychiatry) and physical therapy or other treatment modalities, if recommended. Failure to do so may lead to discontinuation of your medication and referral to another provider or treatment center.

7. Successful pain management entails employing multiple interventions, including active participation in regular physical exercise and the use of psychological coping strategies. A pattern of passive reliance on medications,

resistance to more active physical treatments, and repeated failure to demonstrate the implementation of psychologically based coping strategies may lead to discontinuation of medications and/or referral to another provider or treatment center.

Opioids may cause drowsiness that can be worsened with alcohol, benzodiazepines, and other sedating medications. Use care when driving or operating machinery. An overdose can cause severe side effects, even death.

Other common, usually temporary, side effects include nausea, itching, and sweating. Psychological depression and lowered testosterone levels (in men) may also occur. Sleep apnea, if present, may be worsened by opioids. Constipation commonly occurs, and often does improve with time. It is impossible to predict opioid side effects in any individual patient. Having side effects on one opioid does not necessarily mean there will be side effects on another opioid.

You must take opioids only as directed. Federal law prohibits giving this medication to anyone else. Physical dependence will develop with regular use, but does not by itself indicate addiction; this means that a withdrawal syndrome will develop if you stop your medication abruptly. Tolerance may develop to the pain relieving effects of opioids; this means that the pain relief may decrease over time, but in chronic pain states this usually occurs slowly, if at all.

Not all pain conditions respond to opioids. Some pain may be only partially responsive to opioid therapy. Total elimination of pain is an unrealistic goal. Escalating dosages may indicate that opioids are not effective or that there is an underlying problem with addiction or psychological dependence. Discontinuation of opioid medications may need to be done under these circumstances: not enough pain relief, persistent side effects, not achieving goals of opioid treatment (such as improvement in function), problematic dose escalation, or inability to comply with the treatment agreement.

I have discussed the risks, benefits and alternatives to opioid treatment with my provider. I have had an opportunity to ask questions and receive answers to those questions to my satisfaction.

I give permission to my provider to contact my other healthcare providers, for the purposes of sharing information concerning my situation, as is deemed necessary for coordinated, high quality care.

If I do not follow these guidelines fully, my provider may taper and stop opioid treatment and dismiss me from the practice.

A copy of this document has been given to me.

Patient Signature: _____ Date:_____

Provider Signature: _____ Date:_____