



COMPLETE CARE

Opioid Medication Management Agreement

Patient Name: _____

MR#: _____ **Patient DOB:** _____

Provider: _____

Condition Being Treated:

Medication(s):

1. _____
2. _____
3. _____

Purpose of Treatment

The goal of opioid therapy is to improve function and quality of life. Complete elimination of pain is not expected. Continued treatment will be based on progress toward functional improvement and overall safety.

Patient Responsibilities

I agree to the following:

1. Medication Use

I will take this medication exactly as prescribed. I will not change the dose or frequency without approval from my provider.

2. Monitoring and Safety

I agree to:

- Participate in random urine or blood drug screening when requested



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- Allow my provider to review prescription history through the Prescription Drug Monitoring Program (PDMP)
- Provide accurate information regarding all medications I am taking

3. Prescribing and Pharmacy Use

- I will receive prescriptions for controlled medications only from this provider or clinic unless in an emergency
- I will notify my provider within 48 hours if another provider prescribes controlled medication
- I will use one designated pharmacy:

Pharmacy Name: _____

4. Refills and Medication Security

- Refills will not be provided early
- Lost, stolen, or destroyed medications will not be routinely replaced
- Refill requests must be made at least 48 hours in advance during business hours

5. Appointments and Treatment Participation

- I will attend scheduled appointments with my provider and any recommended specialists (e.g., behavioral health, physical therapy)
- Repeated missed appointments or lack of participation in recommended care may impact continuation of medication management

6. Comprehensive Pain Management

I understand that effective pain management may include multiple approaches, such as:

- Physical activity or therapy
- Behavioral or psychological support
- Lifestyle modifications



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Active participation in these areas is expected when recommended.

Medication Risks and Safety

I understand that opioid medications:

- May cause drowsiness and impair my ability to drive or operate machinery
- Carry a risk of overdose, especially when combined with alcohol, benzodiazepines, or other sedating medications
- May cause side effects such as nausea, constipation, itching, or hormonal changes
- Can lead to physical dependence and tolerance over time

I understand that combining opioids with benzodiazepines, alcohol, or other sedating medications may not be considered safe and may not be continued.

Treatment Expectations

- Opioid therapy may not be effective for all types of pain
- Increasing doses may not improve pain and may indicate the need to reassess treatment
- Continuation of opioid therapy is not guaranteed and will be regularly re-evaluated

Changes to Treatment Plan

If concerns arise regarding safety, effectiveness, or adherence to this agreement:

- My provider may modify my treatment plan
- Opioid medications may be tapered or discontinued
- I may be transitioned to another provider or level of care better suited to my needs

If opioid therapy is discontinued, my provider may offer a tapering plan or short-term transition support when appropriate.

Care Coordination

I give permission for my provider to communicate with other healthcare providers involved in my care as needed to support safe and coordinated treatment.



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Acknowledgment

I have discussed the risks, benefits, and alternatives to opioid therapy with my provider.

I have had the opportunity to ask questions and understand the expectations outlined above.

I agree to follow this treatment plan.

A copy of this agreement has been provided to me.

Patient Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____