Holland Hospital

PAIN MANAGEMENT

Pain Management Agreement

Patient: _____ Date of Birth.: _____

I understand, accept, and agree to the following terms and conditions in order to receive care for the treatment of pain at Lakeshore Health Partners Pain Management office (place your initials next to each statement):

☐ I understand that my provider and I will work together to find the most appropriate treatment for my chronic pain. I understand the goals of treatment are not to eliminate pain, but to partially relieve my pain in order to improve my ability to function. Chronic opioid therapy may be only one part of my overall pain management plan.

☐ I understand that my provider and I will continually evaluate the effect of opioids on achieving the treatment goals and make changes as needed. I agree to take the medication at the dose and frequency prescribed by my provider. I agree not to increase the dose of opioids on my own and understand that doing so may lead to serious harm and cause my provider to choose to stop treatment with opioids.

☐ I understand that the common adverse effects of opioid therapy include constipation, nausea, sweating, itchiness of the skin, confusion or other changes in mental state or thinking ability, and problems with coordination or balance. I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness disappears.

☐ I will not seek opioid medications from another physician for the treatment of my pain. Regular follow up care is required and only my provider will prescribe these medications for my chronic pain at our scheduled appointments.

☐ I will attend all appointments, treatments and consultations as requested by my provider and follow pain management recommendations.

☐ I will not give or sell my medication to anyone else, including family members, nor will I accept any opioid medications from anyone else. I agree to be responsible for the secure storage of my medication at all times. If my medications are stolen, I understand that no new medications will be provided until my already scheduled renewal is due.

☐ I understand that if my prescription runs out early for any reason (for example, if I lose the medication or I take more than prescribed), my provider will not prescribe an early renewal.

☐ I understand that using or attempting to use a forged or falsified prescription will result in the immediate discharge from the practice and notification of the appropriate law enforcement agencies.

☐ I understand that the use of other medications in conjunction with opiates can cause adverse effects (including serious physical harm and even death) or interfere with opioid therapy. Therefore, I agree to notify my provider of the use of all substances, including marijuana, alcohol, medications not prescribed for me, and all illicit drugs. Failure to do so will result in the cessation of opioid prescriptions.

☐ I understand that I may become physically dependent upon opioid medications, which in certain patients may lead to addiction. I agree that if necessary, I will permit referral to addiction specialists as a condition of my treatment plan.

☐ I understand that my provider will not provide me with refills by phone or at night or on weekends. I will not call the after hour's emergency number seeking medication. I understand that it is my responsibility to call my doctor at least five business days in advance of running out of medications if there is a problem. This also means that I will call the pharmacy to ensure any prescriptions due for refill will be available prior to the date of refill, especially prescriptions due for refill over the weekend. I understand that I cannot call after hours or on the weekends about medications that, for whatever reasons, are not at the pharmacy. Furthermore, I am responsible for ensuring that I have an appropriate follow up appointment for receiving my refills. I understand that if I miss my follow up appointment, no further medication renewals will be provided until I am seen in follow up. I understand that failure to do so may result in me going without medication for a significant period of time which may result in untreated pain and even withdrawal symptoms.

☐ I agree to periodic unscheduled drug screens. I understand that I may be asked to provide a urine sample at any time during my treatment while receiving opiates. Failure on my part to provide a sample within 24 hours of the request will result in the discontinuation of opiate prescriptions. I understand that if a drug screen is positive for illegal substances, substances not disclosed to my provider or negative for prescribed medications, I will be discharged from the clinic immediately. I also understand that there will be no discussions, debates or opportunities for re-sampling if the drug screen is positive.

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☐ I understand that my failure to meet any of the requirements of this agreement may result in my provider choosing to stop writing prescriptions for me. In this case, my doctor may choose to taper my medications over a period of several days, as necessary, to avoid withdrawal symptoms. If this is not deemed to be a viable option, I understand that I may be discharged and provided with a 30 day supply of medication for use while I find a new physician to provide me with medical care. I understand that withdrawal from medications will be coordinated by my provider and may require specialist referrals. I understand that there may also be instances in which my provider may decide not to provide any further prescriptions for opiates (this will particularly be true if drug screens are negative for prescribed opiates or if there are illegal substances in my drug screen that may give my provider concern over providing any further prescriptions).

☐ I hereby agree that my provider has the authority to discuss my pain management with other health care professionals and my family members when it is deemed medically necessary in the provider's judgment.

☐ My provider may obtain information from State controlled substances databases and other prescription monitoring programs. I authorize my providers and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse sale or other diversion of my pain medicine. I authorize my provider to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

☐ To the best of my knowledge, I am not pregnant at this time. I understand that opioids are considered dangerous to a fetus. I will do everything possible to avoid getting pregnant while taking these medications unless otherwise approved by my provider.

Physician's Signature: _____ Date: _____