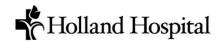


PAIN MANAGEMENT

Opioid Management Agreement

Patient N	Name: Patient Date of Birth:
	tand, accept, and agree to the following terms and conditions in order to receive care for the treatment of pain at the Hospital 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. 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.





PAIN MANAGEMENT

Signature of witness:	Date:
Relationship to patient (if signed by someone other than the patient)
Signature of patient/legal guardian:	Date:
To the best of my knowledge, I am not pregnant at this time a fetus. I will do everything possible to avoid getting pregnapproved by my provider.	
My provider may obtain information from State controlled sprograms. I authorize my providers and my pharmacy to contend enforcement agency, including this state's Board of Pharmacother diversion of my pain medicine. I agree to waive any awith respect to these authorizations.	poperate fully with any city, state or federal law acy, in the investigation of any possible misuse, sale, or
I hereby agree that my provider has the authority to discuss professionals and my family members when it is deemed m	
I understand that my failure to meet any of the requirement stop writing prescriptions for me. In this case, my doctor meseveral days, as necessary, to avoid withdrawal symptoms. That I may be discharged and provided with a 30 day supply provide me with medical care. I understand that withdrawal may require specialist referrals. I understand that there may provide any further prescriptions for opiates (this will particularly opiates or if there are illegal substances in my drug screen further prescriptions).	nay choose to taper my medications over a period of If this is not deemed to be a viable option, I understand y of medication for use while I find a new physician to I from medications will be coordinated by my provider and y also be instances in which my provider may decide not to ularly be true if drug screens are negative for prescribed
I agree to periodic unscheduled drug screens. I understand during my treatment while receiving opiates. Failure on my will result in the discontinuation of opiate prescriptions. I us substances, substances not disclosed to my provider or neg the clinic immediately. I also understand that there will be the drug screen is positive.	part to provide a sample within 24 hours of the request inderstand that if a drug screen is positive for illegal pative for prescribed medications, I will be discharged from
I understand that my provider will not provide me with refil after hour's emergency number seeking medication. I under five business days in advance of running out of medications pharmacy to ensure any prescriptions due for refill will be a due for refill over the weekend. I understand that I cannot that, for whatever reasons, are not at the pharmacy. Further appropriate follow up appointment for receiving my refills. I further medication renewals will be provided until I am seen me going without medication for a significant period of time symptoms.	erstand that it is my responsibility to call my doctor at least is if there is a problem. This also means that I will call the vailable prior to the date of refill, especially prescriptions call after hours or on the weekends about medications ermore, I am responsible for ensuring that I have an understand that if I miss my follow up appointment, no in follow up. I understand that failure to do so may result in

