Opioid and Controlled Substance Agreement

Patient Name:_____

Prescriber Name:_____

Date of Birth:_____

Today's Date:_____

Background: The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe them for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, stimulants, hypnotics, barbiturate sedatives, and testosterone has a potential risk to your health.

In addition, because these drugs have potential for abuse or diversion, strict accountability is necessary. For this reason the following policies are agreed to by you, the patient, as consideration for your provider to consider the initial and/or continued prescription of controlled substances to treat your medical condition _____.

Addiction: I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. It is much more common in a person who has a family or personal history of addiction. I agree to tell my medical provider my complete and honest personal drug history and that of my family to the best of my knowledge.

Tolerance: I am aware that tolerance to opioids means that I may require more medicine to get the same amount of pain relief and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

Opioid and Controlled Substances medication refills

Please initial the following so we know you understand each of the following.

_____The provider who prescribes my opioid or Controlled Substance medication is _____.

_____I agree that my provider team will be the only ones prescribing opioids or Controlled Substances for me. I will tell my provider team about any other medications prescribed to me. I will tell other health care providers about opioid medications prescribed by my provider team.

_____I will use the same pharmacy for obtaining all prescriptions for my pain or other medical condition:

Pharmacy Name: _____Phone: _____

I know that:

_____Opioid prescriptions will be written for **no more than 30 days,** with no refills provided.

_____ I must sign an up to date Opioid and Controlled Substance Agreement. Urine drug test, and state drug database check will be done at random times as determined by your provider.

_____ Early refills will not be given. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. No refills will be given prior to the next scheduled appointment date. If I do not keep the appointment, I will not receive a refill. Refills will never be provided by telephone.

_____ Appointments for refill requests may take up to 3 business days to schedule. A business day is a day that the clinic is open (Monday-Friday). For example, if I request an appointment on a Thursday, I can expect to be scheduled by Tuesday of the following week.

_____ I will not receive a refill for a lost, stolen, damaged, or spilled opioid or controlled substance prescription.

_____ I will no longer be prescribed opioids or controlled substances if I am arrested or put in jail related to legal or illegal drugs.

Lowering harm

To lower the potential for harm from my opioid medication I agree that:

_____ I am aware that the use of such medicine has certain risks, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete relief.

_____ (Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical/sexual performance.

_____ (Females only) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon opioids or controlled substances. Birth defects can occur whether or not the mother is on these medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid or controlled substances.

_____ I will take my opioid or controlled substances as prescribed. I will not take more than my prescribed amount without receiving instructions from my provider and will not run out of my medication early.

_____ I will not share my opioid or controlled substances with anyone or sell them to anyone. This is a violation of federal law and will cause my provider to stop prescribing them to me.

_____ I agree to take only the opioid or controlled substances prescribed to me, even if another person offers me the same medication, or another opioid or controlled substances that I have used in the past.

_____ I will not take street drugs or recreational drugs or abuse alcohol.

_____ I will not operate motorized equipment after beginning an opioid or controlled substance or after a change (such as a dose increase) until I know how the medicine affects me. I will not drive or operate motorized equipment if I ever feel drowsy, dizzy, or not quite myself.

_____ Theft or illegal use of opioid or controlled substances is common. Therefore, I will hide or secure my opioid or controlled substances.

_____ I will get rid of any unused opioid or controlled substances in a safe way, such as at Westminster Medical Clinic, a drop box at certain pharmacies or police departments.

_____ I know the clinic must notify the police if it believes there is illegal activity relating to my opioid or controlled substances, such as selling or giving away my opioid or controlled substances to other people.

_____ I understand that if I abruptly stop my opioid or controlled substance that I may have withdrawal symptoms.

Provider-patient partnership

Please initial the following so we know you understand each of the following.

_____ I know opioid medications will not get rid of my pain completely, and the goal for treatment is to improve my day to day function. I know participating in activities I enjoy, daily physical activity such as walking, and other activities like deep breathing and mindfulness meditation can be as or more effective than opioid medication.

_____ I agree that my provider team may require that a behavioral health provider, health coach, and/or physical therapist be part of your health care team.

_____ I agree to tell my provider team of any over-the-counter drugs, vitamins, and herbal medicines I am taking.

_____ I agree to tell my provider within 48 hours if I have a drug overdose.

_____ I agree to random urine/blood screening (drug testing) at any time during treatment.

_____I know I must schedule and attend all scheduled follow-up appointments. If I cannot come, I will call at least 24 hours in advance to reschedule my appointment.

_____I know any verbally or physically threatening abusive behavior toward providers or staff will lead to no further refills of my opioid medication.

_____I know other doctors, pharmacists, and/or other health workers can discuss my medical condition or report any suspected violations of this agreement to my medical provider.

_____I know my provider may stop prescribing opioid medication or controlled substance if I do not follow this agreement.

By signing below, I agree that I have read and understood the above. Any questions I have about this agreement have been answered to my satisfaction. If I am not able to keep the promises made in this agreement, I will inform you. I understand that if I do not follow this agreement, my provider can choose to stop providing my opioid medication treatment. If this occurs, I understand that the clinic will let me know this in person or at my last known address or phone number.

Patient/legally authorized representative signature: _____

Date: _____

Prescribing Provider signature: _____

Date: _____

My Provider Team: _____