Opioid Medication Agreement For Treatment of Chronic Pain

The purpose of this agreement is to structure our plan to work together to treat your chronic pain. This will protect your access to controlled substances and our ability to prescribe them to you. Completing this form means that IF you are an opioid candidate that you agree to abide by the agreement. By initialing the statements below, I acknowledge that I understand the following:

☐ Opioids have been prescribed to me on a trial basis. One of the goals of this treatment is to improve my ability to perform various functions, including return to work. If significant, demonstrable improvement in my

Goal or improved function:

☐ Opioids are being prescribed to make my pain tolerable but may not cause it to disappear entirely. If that goal is not reached, my provider may end the trial.

Goal for reduction in pain:

☐ Drowsiness and slowed reflexes can be a temporary side effect of opioids, especially during dosage adjustments. If I am experiencing drowsiness while taking opioids, I agree not to drive a vehicle nor perform other tasks that could involve danger to myself or others.

☐ Using opioids to treat chronic pain will result in the development of a physical dependence on this medication, and sudden decreases or discontinuation of the medication might lead to symptoms of opioid withdrawal. These symptoms can include: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, vomiting, irritability, aches and flu-like symptoms. I understand that opioid withdrawal is uncomfortable but not physically life threatening.

☐ There is a small risk that opioid addiction can occur. Addiction is occurring if a patient loses control of taking an opioid for pain treatment. It is not frequently recognized by patients on opioids. If it appears that I may be developing addiction, my provider may determine to end the trial.

☐ Opioid medications are only a portion of a larger treatment plan. I will participate fully in treatment and follow my providers' recommendations regarding physical therapy, psychotherapy, vocational rehabilitation, counseling, other medication, and other prescribed or recommended treatment.

☐ I will obtain my pain medication prescriptions only from this clinic, and to notify other providers, including ERs and hospitals that I am being treated with these medications. This requirement is to protect me from the danger of receiving too much medication. I will notify the office immediately if I obtain any pain medication from an emergency room or urgent care clinic. I understand that my providers may check the Iowa and/or Illinois PMP (Prescription Monitoring Program) and if aberrant behavior occurs that my providers may report such behavior to the PMP of Iowa or surrounding states.

☐ I agree to submit to random urine, blood or saliva testing, at my provider's request, to verify compliance with this agreement, and to be seen by an addiction specialist if requested. I will bring in my pills to be counted on each visit or whenever asked of me.

☐ I agree not to use illegal drugs

☐ I agree not to share, sell or in any way provide my medication to any other person.

☐ I understand that my providers may freely share my medical record with other health care professionals that are providing care to me including emergency room and urgent care facility personnel, primary care or specialty providers, and pharmacies requesting additional information regarding the diagnosis being treated at PCI, P.C. I may rescind this permission at any time by requesting the appropriated HIPAA form at the offices of PCI, P.C.

☐ I agree to notify PCI, P.C., if I receive pain treatment at any other clinic where pain treatments are carried out. I understand that PCI, P.C., considers treatment of pain by any other provider other than one associated with PCI, P.C., while I am receiving care at PCI, P.C., is not consistent with continuity of care and that upon learning of this that I may be discharged from PCI, P.C., as per discharge policy. This policy exists because many pain clinics provide only injection therapies and not complete care of a patient that may include medication therapies. I understand that it is entirely my choice where to go and what care to receive from the many choices available to me and that it is entirely the choice of PCI, P.C., to implement discharge of patients who only seek to have their medication management done by PCI, P.C., while receiving injection therapies elsewhere. I understand that PCI, P.C., respects my decisions and that I, in turn, respect PCI, P.C., decisions about such matters.

****FOR WOMEN ONLY:** I understand that use of opioid or other medications may adversely affect a fetus if taken during pregnancy, or if used while breastfeeding. If I am pregnant now, or become pregnant, or am breastfeeding, I will notify my primary care or obstetric provider as well as PCI, P.C. providers.

I understand that violation of ANY of the above agreement may be grounds for dismissal from the pain clinic, and the provider to stop prescribing opioid therapy at any time.

Write the above statement in your own handwriting in this box.

Patient Name _____ Date _____