

PATIENT-PROVIDER CONTRACT FOR THE USE OF CHRONIC OPIOIDS

I, _____, realize that my provider has decided to try and relieve my suffering partly with the use of opiate analgesics (pain medicines). I recognize that these medicines have risks, including addiction, and benefits, which have been explained to me by my provider, and that these medicines are only one component of my pain treatment regimen.

I appreciate that in order to receive continuing care by my provider for my chronic pain, I will adhere to the following mutual expectations:

1. Pain medicines will be used only as directed for my pain. I will NOT:

suddenly stop taking these medicines;

use them for uses other than treating my pain;

increase the dose without discussion with my provider;

share them with others.

2. I will receive narcotics only from Dr. _____ and from no one else, including ER visits.

3. I will have my prescriptions filled only at one pharmacy of my choice, which I have clearly specified with Dr. _____.

4. I will ask Dr. _____ for refills on a predetermined schedule, only asking when I still have at least four days' worth of medication remaining. I will not request medications from covering doctors.

5. Refills will be given only at Dr. _____ office. They will not be mailed.

6. I will adhere to requests for random drug testing should my provider ask me.

7. It is my responsibility to protect my prescriptions from loss, theft or damage. A police report will be required for any report of theft before my provider will consider replacing them. If a second loss, theft or damage occurs, I realize my provider may choose to not replace them.

8. These pain medicines are only one component of my treatment strategy. I agree to adhere to other aspects of my care as discussed with my provider.

Patient Signature Date

Provider Signature Date