Opioid Medication for Chronic Pain Agreement

This is an agreement between_____ (patient) and_____ (clinician).

Although opioids are unlikely to completely rid me of my pain, they are intended to decrease it enough that I can be more active. Because this medication has risks, side effects, and street value, I understand that my clinician needs to monitor my treatment closely to keep me safe. I acknowledge my treatment plan may change over time to meet my functional goals and that my medication, dosage, and adherence to the plan will be closely monitored. I understand that opioids are not intended to be a sole therapy or lifelong medication.

Patient Initials	Please Read the Statements Below and Initial in the Box at the Left.
	I have reviewed, understand, and accept the risks associated with opioid therapy and the opioid stewardship policies in place at this institution.
	I understand that the medication may be stopped or changed to an alternative therapy if it does not help me meet my functional goals.
	To reduce risk, I will take the medication as prescribed. I will not take more pills or take them more frequently than prescribed.
	I will inform my clinician of any side effects I experience.
	To reduce risk, I will not take sedatives, alcohol, or illegal drugs while taking this medication.
	I will submit to urine and/or blood tests to assist in monitoring my treatment.
	I understand that my clinician or his/her staff may check the state prescription drug database to guard against overlapping prescriptions.
	I will receive my prescription for this medication only from_____.
	I will fill this prescription at only one pharmacy. (Fill in pharmacy information below.)
	I will keep my medication in a safe place. I understand that if my prescription is lost, damaged, or stolen, it will not be replaced.
	I will do my best to keep all scheduled follow-up appointments. I understand that I may not receive a prescription refill if I miss my appointment.

Medication Name, Dose, Frequency: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____

By signing below, we agree that we are comfortable with this agreement and our responsibilities.

_____ _____

Patient Signature **Date**

_____ _____

Clinician Signature **Date**

Adopted from the American Academy of Family Physicians pain contract.

This material was prepared by the Iowa Healthcare Collaborative, the Opioid Prescriber Safety and Support contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS.

Developed in collaboration with Stader Opioid Consultants.