Re: Pain medication agreement

I, patient's name, am a patient under the care of responsible provider, my primary care doctor. As a part of my long term care for chronic pain, I have been given a controlled substance medication. I recognize that for my safety, the providers in the Division of General Medicine have specific policies regarding the chronic use of controlled substances. In order to continue receiving this medication, I agree to the following terms:

1. I will not request or accept controlled substance medications from any other physicians or individuals outside of the Division of General Medicine at Tufts Medical Center. The only exceptions are if the medication is prescribed while I am admitted in a hospital, or after discussion with my primary care physician.

2. I will not take any more medication than prescribed unless I speak with my doctor, nurse, or nurse practitioner at the office first.

3. I am responsible for my controlled substance medication. I will not expect to receive additional medication before my next scheduled refill, even if my prescription runs out, or if my prescription or medication is lost, misplaced, or stolen. I am aware that I must report stolen medications to the police.

4. I am responsible for obtaining refills for my controlled substance medication. I agree to call at least 72 hours in advance to request refills. I understand that refills will be made only during regular office hours, 8AM-5PM Monday - Friday. Refills will not be made at night, on holidays or weekends.

5. I understand that a main treatment goal is wean off my controlled substance medications, while any recommendations my doctor makes for special testing or referrals to specialty clinics. Refusing to participate in testing or evaluation may result in termination of my treatment.

6. If my doctor asks, I agree to submit to urine and blood screening to detect the use of non-prescribed medications at any time.

7. I am aware that the use of such medicine has certain risks associated with it, 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, death, and the possibility that the medicine will not provide complete pain relief.

8. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

I understand that if I violate any of these terms, I may be discharged from the General Medicine practice upon a 30 day notice of termination.

The specific medication(s) that this contract pertains to are:

________________________________________

Patient name                                      Date

________________________________________

Provider name                                      Date
Policy Title: Ambulatory Management of Chronic Non-Cancer Pain Using Opioids in Adults

Approval Signature/Title: Chief Medical Officer

Date: