

# CONTROLLED SUBSTANCE REFILL PROGRAM: PATIENT AGREEMENT FORM

## Treatment Agreement for Chronic Opioids

We want to ensure that patients and caregivers have clear communication and safe, effective procedures when patients use opioids.

**EFFECTIVENESS:** For most patients and pain conditions, opioids are effective pain-relieving medications. However, it is possible opioids will not work well for you and your pain.

**SAFETY:** Most people can take these drugs safely, but some people do experience side effects. (See below.)

**SIDE EFFECTS:** Most patients do not have serious side effects or drug interactions. Unfortunately, some do experience side effects and must stop the medication(s). Common side effects include constipation, itching, nausea, vomiting, sedation or lightheadedness. Uncommon reactions include swelling in the legs, water on the lungs, trouble breathing (especially if you have emphysema/COPD or are on other narcotics), mental slowing and loss of coordination, lowering of sex drive, decreased testosterone (male sex hormone) and addiction. Note: Pregnant women using opioids could make their newborn child dependent upon opioids. If you are pregnant, you need to alert your health care provider.

**DEPENDENCE:** Dependence is not the same as addiction. Many people who take opioids daily will become dependent on them. Dependence is when your body adapts to the medication and then experiences withdrawal if the medication is stopped or lowered too quickly. Withdrawal symptoms include moodiness, aches and pains, sweating, diarrhea, abdominal pain and even seizures.

**ADDICTION:** Addiction is not the same as dependence. While many people become dependent on daily opioids, only a small percentage of these people will become addicted. Addiction is characterized by behaviors such as loss of control of drug use, compulsive use and craving, and continued use despite harm or risk to the person. When people are addicted, they are not taking opioids simply to treat the pain.

**GOALS:** The goals of chronic pain management are to:

- 1 Improve your ability to function in your daily life,
- 2 Lower your pain.

### TREATMENT OPTIONS :

- 1 Medications,
- 2 Counseling, relaxation training, hypnosis and meditation,
- 3 Chiropractic care, massage, acupuncture and physical therapy,
- 4 Surgery and injections.

### WHAT YOU NEED TO DO :

- 1 Realize that opioid therapy is only one part of treatment.
- 2 Remain active every day and try to increase activity a little bit at a time.
- 3 Use your medications ONLY as directed by your provider.
- 4 Work with your provider and follow treatment recommendations in addition to taking prescribed medications.

Dr. \_\_\_\_\_ and staff have explained the risks and benefits of chronic opioid therapy for my pain.

I, \_\_\_\_\_, understand that I must comply with the following rules or I will not be given opioids.

I will fill the prescription at one and only one pharmacy.

Pharmacy name \_\_\_\_\_ Phone \_\_\_\_\_

continued ►



**FPM Toolbox** To find more practice resources, visit <https://www.aafp.org/fpm/toolbox>.

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I will take the medication, \_\_\_\_\_, as it was prescribed and only in that way.

I will not increase the dose or stop the medication unless asked to do so by my provider or my provider's partner.

I will report any worrisome side effect soon after it begins.

I will follow through on appointments that may help me with chronic pain and functioning. These may include physical and occupational therapy, counseling and other mental health practices, neurosurgery, neurology and orthopedics. Consistent failure to keep these appointments and therapies may result in the stopping of the opioid medications.

If prescribed, I will use medications other than opioids to control pain.

I will accept opioids for chronic pain from my provider only.

I will not share, exchange or sell my opioids, as the law prohibits those actions. I understand that my provider will report serious concerns of drug misuse to any and all authorities for investigation.

I will not use illegal/street drugs (this includes marijuana). I will not use narcotic medications unless provided to me from my provider.

I agree to provide samples for random drug testing when asked. If I fail to provide the sample when asked or if the results are unsatisfactory, I may forfeit the right to continue receiving the medication.

If my provider is concerned that I might have a substance abuse problem, I must agree to an evaluation by a specialist in abuse/addiction. If the evaluation suggests I have a drug abuse problem, my provider may stop my medication in a way that does not cause withdrawal symptoms.

I will not get early refills unless something has dramatically changed and then only if my provider agrees.

I recognize that opioids by themselves, in combination with alcohol or in combination with other medications can result in unclear thinking and loss of coordination. I agree to contact my provider if these symptoms arise. I should not drive or operate equipment if I have these side effects.

It is my responsibility to keep my medications safe. If opioids are lost, damaged or stolen, the medication may or may not be refilled early. Each case will be looked at individually. If the medication is stolen, I must file a police report and submit the number for verification to my provider's office. Again, stolen medications may or may not be refilled. If a refill is given, it will be given only once.

If a new condition develops that causes acute pain, I have the right to expect appropriate treatment for that new condition from the provider treating me for the new condition. I should not be required to increase the use of my chronic pain medication for a serious and new pain.

I understand that if my provider does not feel I am following through adequately with the treatment plan, my provider may lower or stop the opioid altogether.

I understand that my provider may decide to stop the opioid if after increasing it adequately, my pain and function have not responded positively.

By signing this form, I authorize my provider's office to contact any and all groups and organizations involved with my care and involved with the investigation of medication and drug abuse. I give permission to my provider to discuss my care with past caregivers, all pharmacies and policing agencies. This also gives these caregivers and pharmacies permission to share with my provider information about my past treatments and care

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Health care provider \_\_\_\_\_ Date \_\_\_\_\_