Pain Management Agreement

I understand that Dr. _____ is prescribing opioid medication to help me manage chronic pain that has not responded to other treatments. The goal of this medication is to lead to partial relief from pain, so that my physical, emotional, and social function will improve. If my activity level or general function gets worse, the opioid may be stopped or changed to something else. The risks, side effects and benefits of opioid treatment have been explained to me and I agree to the following instructions. Failure to follow these instructions may result in stopping the medication.

1. I will participate in any **other treatments** recommended by my provider**.** I will be ready to decrease or stop the opioid medication when other effective treatments become available.

2. I will take my medications **exactly as prescribed** and will not change the medication schedule or dosage without advance approval from my provider. I will provide my medication for pill counts at the provider's request. I will not request early refills.

3. I will keep **regular appointments** with my provider.

4. All opioid and other controlled drugs for pain must be prescribed **only** by Dr. _____.

5. I will inform my provider within **a week of discharge** if I am **hospitalized** for any reason, or if I have another condition that requires the prescription of a **controlled drug** (like narcotics, tranquilizers, barbiturates, or stimulants).

6. I will choose **one pharmacy** where all of my prescriptions will be filled.

   Pharmacy Name: _____
   Phone Number: _____
   Fax Number: _____
   Address: _____
   _____

7. I understand that lost or stolen prescriptions will **not be replaced**, so I will keep my prescription and medication in a safe place. I will not under any circumstances sell, lend, or give my medication to others.