

PATIENT TREATMENT AGREEMENT

Patient Name: _____

Medical Record #: _____

Referring Physicians: _____

GENERAL PROVISIONS

- You agree to keep all scheduled appointments, not just with your physician, but also with recommended therapists and psychological counselors. Three or more missed appointments or same day cancellations will lead to patient dismissal.
- You agree to provide regular as well as random samples for drug screens. Positive test for any illegal substances or opioids, not prescribed by your pain doctor, will result in your dismissal and referral elsewhere for substance abuse evaluation and management.
- You agree to comply full with all aspects of your treatment program including behavioral medicine (psychology /psychiatry) and physical therapy, if recommended. Failure to do so may lead to discontinuation of your medication and referral to another provider or treatment center.
- Successful pain management entails employing multiple interventions, including active participation in regular physical exercise and the use of psychological coping strategies. A pattern of passive reliance on medications, resistance to more active physical treatments, and repeated failure to demonstrate the implementation of psychologically based coping strategies that have been taught to you may lead to discontinuation of medications and/or referral to another provider or treatment center.

MEDICATION RELATED PROVISIONS

Goals for taking opioid medications: _____

Medication and proposed duration of use:

- If we prescribe pain medication for you only your pain doctor will prescribe opioid medications for you.
- You agree not to ask for opioid medications from any other doctor without the knowledge and assent of your pain doctor.
- No prescriptions will be refilled early
- No prescriptions will be refilled if you lose, destroy or have any of your medication stolen.
- Prescriptions will be refilled in person, only during regular office hours.

We understand that emergencies can occur and under some circumstances, exceptions to these guidelines may be made. Emergencies will be considered on an individual basis.

Opioids may cause drowsiness that can be worsened with alcohol, benzodiazepines (such as Valium) and other sedating medications. Use care when driving or operating machinery. An overdose can cause severe side effects (such as seizures) or even death.

Other common, usually temporary side effects include nausea, itching, sweating and difficulty concentrating at work. Psychological depression and lowered testosterone (male sex hormone) levels may also occur (leading to difficulty in having an erection, lowered sperm counts and impaired fertility). Sleep apnea if present may be worsened by opioids. Constipation commonly occurs, and often does not improve with time. It is impossible to predict opioid side effects in any individual patient.

Having side effects with one opioid does not necessarily mean that there will be side effects with another opioid.

You must take opioids only as directed. Federal law prohibits giving this medication to anyone else. Physical dependence will develop with regular use, but does not by itself indicate addiction; this means that a withdrawal syndrome (symptoms including nervousness, nausea, sweating and seizures) will develop if you stop your medication abruptly. Tolerance may develop to the pain relieving effects of opioids; this means that the pain relief may decrease over time, but in chronic pain states this usually occurs slowly, if at all.

Not all pain conditions respond to opioids. Some pain may only be partially responsive to opioid therapy. Total elimination of pain is an unrealistic goal. Escalating dosages may indicate that opioids are not effective or that there is an underlying problem with addiction or psychological dependence. Discontinuation of opioid medicines may need to be done under these circumstances: not enough pain relief, persistent side effects, not achieving goals of opioid treatment (such as improvement in function), problematic dose escalation, or inability to comply with the treatment agreement.

I, the undersigned, agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered.

I give permission to my pain doctor to contact my other healthcare providers, for the purposes of sharing information concerning my situation, as is deemed necessary for coordinated high quality care.

If I do not follow these guidelines fully, my doctor may taper and stop opioid treatment and refer me elsewhere for care.

A copy of this document has been given to me.

Patient signature: _____

Witness signature: _____

Date: _____