Long Term Pain Agreement

As part of your overall pain management plan, your provider (physician, physician assistant or nurse practitioner) is prescribing opioid (narcotic) medication, which includes Oxycodone, Morphine, Hydrocodone, Tramadol, Hydromorphone and Methadone. These medications are strictly regulated, and have some very serious side effects which can be fatal if you do not follow the plan of care.

Your signature on this agreement means that you will follow all of the terms below and that you understand that if you do not follow your plan of care you will no longer receive opioids.

1. I will take my medication exactly as prescribed and will make no changes unless told to do so by my provider.
2. I will not use alcohol, marijuana (prescribed or not), or any illegal drugs when using opioids.
3. I will not take any benzodiazepines such as Xanax, Valium, Ativan or Klonopin while using opioids because of the high risk for overdose and other severe side effects.
4. I will not ask for early refills for any reason (including medication that is lost or stolen even if that means I will go through withdrawals).
5. I will use only one pharmacy to get my medication and I will call for refills only between 9 a.m. and 5 p.m. Monday through Friday, at least 3 days before my medication is due. My pharmacy is _____.
6. I understand that sharing, selling or altering my prescription will result in my discharge from the program and that I will not be able to receive any controlled substances from any CHC clinic.
7. I will be responsible for my medication and will keep them away from children and animals.
8. I will not accept prescriptions for opioids from anyone other than my provider without permission and that if I am given an opioid from the ER, I will tell them about my agreement and I will report my visit to my provider within 48 hours.
9. I will keep and show up on time for all of my appointments or risk being discharged from the program. If I am unable to make my appointment I will call at least 24 hours in advance.
10. I agree to undergo screening for behavioral health and substance abuse disorders, and if my screenings for these disorders come up positive, I agree to mandatory referral and treatment.
11. I understand I must follow the whole treatment plan. This plan may include referrals to specialists, Physical Therapy, Behavioral Management, self-help programs and more.
12. I understand that my provider may ask for random drug screens or pill counts at anytime and that I will be required to arrive at the clinic within 24 hours of the request. I also understand that if a drug screen is requested that I have only 1 hour to leave an adequate sample and am required to remain in the clinic until a sample is provided.
13. I will notify my provider if I have any side effects or if the medication is not helping. If my medication is changed I will bring unused medication back to my provider's office for disposal.
14. **Females only:** I understand that I should not become pregnant while taking opioids and that if I think I may be pregnant I will immediately notify my provider.
15. I understand that my provider will not tolerate abusive behavior toward any employee of CHC.
16. I understand that this agreement may be shared with other providers and/or facilities and that any violations may be reported back to my provider.
17. I understand that this agreement is in effect for 12 months and that after 12 months my provider and I will review my treatment plan to decide if changes or discontinuation is necessary.

Patient Name	Signature	Date
Provider Name	Signature	Date

MED Form 313A (Rev 07/16)

LONG TERM OPIOID USE INFORMED CONSENT AND INFORMATION SHEET

SIDE EFFECTS/RISKS of opioid (narcotic) pain medications - Patient will initial all items and sign below:

I understand that daily use of an opioid may cause side effects and increase risks to my health and safety, which include but are not limited to:

- ☐ Nausea, vomiting, constipation, and dry mouth
- ☐ Impaired judgment, sleepiness and confusion
- ☐ Breathing problems, including slowing or stopping of breathing
- ☐ Dizziness and increased risks of falls
- ☐ Increased pain or decreased tolerance of pain
- ☐ Allergic reactions, overdose and death
- ☐ Impaired ability to operate machines or drive motor vehicles
- ☐ Worsening of depression symptoms
- ☐ Addiction to the medication
- ☐ Physical Dependence and withdrawal symptoms after suddenly stopping the medication, including:
  - Runny nose, sweating, goose bumps
  - Abdominal cramps, diarrhea
  - Rapid heart rate, nervousness, difficulty sleeping
- ☐ Psychological dependence, meaning stopping the drug will cause you to crave it
- ☐ Tolerance, meaning that you may need more and more of the drug to get the same effect
- ☐ Problems with pregnancy

I ALSO AGREE TO FOLLOW THESE RECOMMENDATIONS FOR MEDICATION MANAGEMENT - Patient will initial all items and sign below:

- ☐ Put my pills in a daily medication dispensing box
- ☐ Use a secure locking box for medication storage
- ☐ Take only a small amount of medication with me when leaving home
- ☐ Come to every CHC clinic visit with a full bladder, in case I need to leave a urine drug screen
- ☐ Agree to pay the full cost of any testing required to manage my pain, including the cost of urine drug screens.

Patient Name	Signature	Date

Provider Name	Signature	Date