

OPIOID PAIN MEDICATION AGREEMENT (3 Parts)

Patient (Part 1): Opioid pain medication is being prescribed for me as one part of my treatment to help better control my long standing pain and to help me reach the goals I have set to feel better (see *Goals and Benefits* on reverse side). In order to make this medication safe and follow national and state laws,

I, _____, understand that:
(name)

- This medication may not take away all my pain, and long-term benefit has not been proven.
- I should follow the directions exactly as given to me by my provider. Taking more than prescribed may hurt me.
- There are side effects of this medication described to me by my provider. All my questions about this medication have been answered. (see *What a Patient Needs to Know About Opioid Medication* on reverse side)
- I will call my provider's office if I am having side effects after starting this medication.
- This medication may make me sleepy, increase my risk of falling, and make driving or operating machinery dangerous.
- Taking alcohol or street drugs along with this medication is dangerous.
- Taking this medication with other prescription drugs can also be dangerous. I will alert ALL my providers about my current medications, including over-the-counter (OTC) medicine, supplements, and herbs.
- My body may get used to the medication and it may not work as well. Also, if I stop it too quickly I could get sick.
- Some people become addicted to these medications. If I think this is happening to me I will speak to my provider.

Patient (Part 2): I, _____, agree:
(name)

- To get pain medication only from the provider signed below, or his/her medical team.
- To notify my provider immediately if I obtain any pain medication from an emergency room.
- To get pain medication only during regular office hours and not to call after office hours for pain medication.
- To fill my medication at only one (1) in-state pharmacy. The contact information is:

Pharmacy name: _____ **Phone:** _____

- To give urine samples and to bring my pills to be counted whenever asked of me.
- Not to use illegal drugs or non-prescribed prescription drugs along with this medication.
- Not to sell or give away my medication.
- To keep my medication safe. If it is lost or stolen, I understand it may not be replaced.
- To allow my provider to exchange information with people who might need to know about my medication use if he/she thinks it is necessary for my health and safety.
- To keep all of my health care appointments recommended to me to treat my pain.
- That my medication can be stopped at any time, after a discussion with my health care provider.

Health Care Provider (Part 3): I, _____, agree:
(health care provider's name)

- To explain your pain condition and how opioids are expected to help.
- To explain the risks, side effects and alternatives to opioid treatment.
- To monitor your pain level at each visit to help assure good pain control and help meet your goals (see *Goals and Benefits*).
- To continue to change the plan as needed to get improved activity and better control of pain.
- To include a pain specialist, and/or other health care specialists (such as Behavioral Health, Physical Therapy, Massage Therapy, Acupuncture) in your care, as needed to reach your goals (see *Goals and Benefits*).
- To make clinical decisions I believe are in your best interest, including discontinuing opioids.
- To keep you safe, to the best of my abilities, including your ability to drive and operate machinery. I will check your prescriptions and referring you for help if you become addicted.

Consent to treatment and Agreement to responsibilities outlined above: My health care provider and I have reviewed this document, including *What a Patient Needs to Know About Opioid Medication* (on reverse side); and I have been given the opportunity to have any questions answered. I understand the possible benefits and risks of opioid medications. My health care provider and I each accept our respective responsibilities described above.

Patient signature

Date

Health Care Provider signature

Date

Patient name printed

Date

Health Care Provider name printed

Date

What a Patient Needs to Know About Opioid Medication

Goals and Benefits

- ❖ If opioid medication is prescribed, it is just one part of a total pain management plan. Expected benefits and goals of opioid medication to treat pain include:
 - Improved pain
 - Improved ability to engage in work, social, recreational and/or physical activities
 - Improved quality of life
 - Improvement of more specific goals I discussed with my provider

Side Effects, Effects of Medication Combinations and Addiction Risk

- ❖ I need to tell my provider if I notice any problems. Opioid pain medications often have side effects, which may include but are not limited to:
 - Itching
 - Rash
 - Nausea
 - Constipation, sometimes severe
 - Trouble urinating or passing stool/poop
 - Drowsiness
 - Slow or depressed breathing (especially if obese)
 - Problems thinking clearly
 - Mood changes
 - Depression getting worse
 - Increased risk of bone fractures or brittle bones
 - May worsen sleep apnea (periods of not breathing while sleeping)
 - Sexual difficulties, such as lack of menstrual periods in women and low male hormone in men
 - Life-threatening irregular heartbeat (methadone)
- ❖ I need to tell my provider about taking any prescription and nonprescription medication/supplements/herbal remedies and street drugs.
 - (1) Taking too much of my opioid medication;
 - (2) Using it with alcohol and/or illegal or borrowed prescription drugs; or
 - (3) Combining opioids with some prescriptions (especially sedatives or anxiety medicines, such as Xanax[®]) AND especially without supervision or my provider knowing) can cause:
 - Overdose
 - Trouble breathing, may stop breathing
 - Brain damage, Coma, Death
- ❖ I need to tell my provider if I am a woman who is pregnant or plans to become pregnant. Risks to unborn children in women include:
 - Physical dependence at birth
 - Possible changes in pain perception
 - Possible increased risk for development of addiction
- ❖ I need to check with my provider or pharmacist before taking any over-the-counter (OTC) medications that contain acetaminophen (i.e., APAP, Tylenol[®]). ALWAYS read labels to check for added acetaminophen. Acetaminophen can be 'hidden' in medicine such as cough/cold or menstrual cramp medicines. Some opioid pain medications (such as Vicodin[®], Lortab[®], Norco[®], Percocet[®]) also contain acetaminophen. Too much acetaminophen may cause liver damage.
- ❖ If I decide to stop my medication, I will contact my provider. If I must stop this medication for any reason, I need to stop it slowly to help me avoid feeling sick from physical withdrawal symptoms. Withdrawal symptoms include:
 - Anxiety
 - Irritability
 - Aching, Pain
 - Sweating
 - Abdominal/Stomach cramping
 - Diarrhea
- ❖ I may develop an increased sensitivity to pain.
- ❖ I could become addicted to this medication. If anyone in my family or I have ever had drug or alcohol problems I have a higher chance of getting addicted to this medication. Addiction is associated with drug craving, loss of control, and poor response to treatment.

Other Risks to Others and Myself

- ❖ If I do not use this medication exactly as prescribed, I risk hurting others and myself (such as a car accident).
- ❖ If I do not secure or dispose of this medication properly, I risk hurting others, especially children, who find it and accidentally take it. There is also a possible risk to my household and me to theft, deceit, assault or abuse by persons seeking to obtain my medications for purposes of misuse.