

VA/DoD Clinical Practice Guideline Opioid Therapy Chronic Pain Sample Opioid Pain Care Agreement

1. I understand that my provider and I will work together to find the most appropriate treatment for my chronic pain. I understand the goals of treatment are not to eliminate pain, but to partially relieve my pain in order to improve my ability to function. Chronic opioid therapy is only ONE part of my overall pain management plan.

2. I understand that my provider and I will continually evaluate the effect of opioids on achieving the treatment goals and make changes as needed. I agree to take the medication at the dose and frequency prescribed by my provider. I agree not to increase the dose of opioids on my own and understand that doing so may lead to the treatment with opioids being stopped.

3. I understand that the common adverse effects of opioid therapy include constipation, nausea, sweating, and itchiness of the skin. Drowsiness may occur when starting opioid therapy or when increasing the dosage. I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness disappears.

4. I will not seek opioid medications from another physician for the treatment of my chronic pain. Regular follow-up care is required and only my provider will prescribe these medications for my chronic pain for me at scheduled appointments.

5. I will attend all appointments, treatments, and consultations as requested by my providers. I will attend all pain appointments and follow pain management recommendations.

6. I will not give or sell my medication to anyone else, including family members; nor will I accept any opioid medication from anyone else. I agree to be responsible for the secure storage of my medication at all times. If these medications are stolen, I will report this to police and my provider and will produce a police report of this event if requested to do so.

7. I understand that if my prescription runs out early for any reason (for example, if I lose the medication or take more than prescribed), my provider may not prescribe extra medication for me. I may have to wait until the next prescription is due.

8. I understand that the use of other medications can cause adverse effects or interfere with opioid therapy. Therefore, I agree to notify my provider of the use of all substances, including marijuana, alcohol, medications not prescribed for me (tranquilizers), and all illicit drugs.

9. I agree to periodic unscheduled drug screens.

10. I understand that I may become physically dependent on opioid medications, which in a small number of patients may lead to addiction. I agree that if necessary, I will permit referral to addiction specialists as a condition of my treatment plan.

11. I understand that my failure to meet these requirements may result in my provider choosing to stop writing opioid prescriptions for me. Withdrawal from the medications will be coordinated by the provider and may require specialist referrals.

12. I hereby agree that my provider has the authority to discuss my pain management with other health care professionals and my family members when it is deemed medically necessary in the provider's judgment.

13. My providers may obtain information from State controlled substances databases and other prescription monitoring programs.

Patient Signature: _____