Patient-Prescriber Pain Management Agreement

Please read both sections before signing this agreement.

For the patient:

I acknowledge that I have uncontrolled pain, which limits my daily functioning. In an attempt to improve my daily functioning, I have tried other pharmacologic and/or non-pharmacologic treatments without success. While this medication's intent is to control my pain, I acknowledge the following with respect to the medication to be prescribed to me:

- This medication may not fully alleviate my pain
- My prescriber has reviewed the risks associated with taking this medication, including side effects and the risk of dependence and addiction
- My prescriber has reviewed the consequences of misuse, including but not limited to, overdose
- My doctor may choose to only give me written / electronic [circle one] prescriptions for this medication
- I understand that my prescriber may, at any time, revoke my ability to receive prescriptions for opioids based on evidence of treatment failure, misuse, and/or dependence and addiction

I also acknowledge the following responsibilities required of me, including, but not limited to:

- I will take this medication exactly as written by the below prescriber, and my prescriber may ask me to bring in my medication bottles to verify I am taking my medication as directed
- I will inform my prescriber of any and all medications I am taking, including new medications prescribed during the duration of treatment with this medication. I will stop taking all other pain medication, unless the prescriber below explicitly informs me otherwise
- I will not seek, accept, or knowingly administer medications for the management of pain other than those that are prescribed by my doctor. This includes using illicit drugs, receiving controlled substances from other prescribers, and obtaining controlled substances from other individuals
- I will not cancel my appointments with this prescriber without due notice
- At any time during the management of my chronic pain, my prescriber can request my completion of a urine drug screen
- I will obtain all of my medications, when possible, from a single pharmacy
- My prescriber may choose to contact other healthcare professionals participating in my care, friends, or family members if such action is deemed necessary by him/her

For the prescriber:

I acknowledge that this patient has tried other pharmacologic and/or non-pharmacologic options for his/her pain, and the next appropriate treatment option is the below medication. As the prescriber for the below medication, I further acknowledge that I will:

- Regularly and thoroughly ensure that the below patient does not experience any untoward side effects, misuse, or dependence and/or addiction from this medication. If this patient does, I will adjust or stop therapy with this medication according to my best judgment
- Keep track of my patients controlled substance use and administer urine drug screens as clinically indicated
- Thoroughly outline a treatment plan, with goals of therapy and expected duration of opioid use
- Help this patient get appropriate treatment should they develop a substance use disorder

Patient name: _____ Patient signature: _____ Date: ___/___/___

Prescriber name: _____ Prescriber signature: _____ Date: ___/___/___

Medication name, strength: _____ Medication sig: _____

Pharmacy name: _____ Pharmacy phone number: (____) ____ – _____