Appendix IV
OPIOID TREATMENT AGREEMENT

Patient Name: _____

Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist in your return to work.

To the doctor: Keep signed originals in your files; give a photocopy to patient. Renew at least every 6 months.

I, _____, understand that compliance with the following guidelines is important in continuing pain treatment with Dr. _____.

1. I understand that I have the following responsibilities:

    a. I will take medications only at the dose and frequency prescribed.
    b. I will not increase or change medications without the approval of this doctor.
    c. I will actively participate in RTW efforts and in any program designed to improve function (including social, physical, psychological and daily or work activities).
    d. I will not request opioids or any pain medicine from physicians other than from this doctor. This doctor will approve or prescribe all other mind and mood altering drugs.
    e. I will inform this doctor of all other medications that I am taking.
    f. I will obtain all medications from one designated pharmacy, and give this doctor consent to speak with the pharmacist about m prescription needs.
    g. I will protect my prescriptions and medications. Only one lost prescription or medication will be replaced in a single calendar year. I will keep all medications from children.
    h. I agree to participate in psychiatric or psychological assessments, if necessary.
    i. If I have an addiction problem, I will not use illegal or street drugs or alcohol. This doctor may ask me to follow through with a program to address this issue. Such programs may include the following:
        - 12 step program and securing a sponsor
        - Individual counseling
        - Inpatient or outpatient treatment
        - Other

2. I understand that in the event of an emergency, this doctor should be contacted and the problem will be discussed with the emergency room or other treating physician. I will sign a consent to request record transfer to this doctor. No more than 3 days of medications may be prescribed by the emergency room or other physician without this doctor's approval.
3. I understand that I will consent to random drug screening. A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.
4. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.
5. I understand that this doctor may stop prescribing opioids or change the treatment plan if:

    a. I do not show any improvements in pain from opioids or my physical activity has not improved.
    b. My behavior is inconsistent with the responsibilities outlined in #1 above.
    c. I give, sell, or misuse the opioids medications.
    d. I develop rapid tolerance or loss of improvement from the treatment.
    e. I obtain opioids from other than this doctor except as allowed in #2 above.
    f. I refuse to cooperate when asked to get a drug screen.
    g. An addiction problem is identified as a result of prescribed treatment or any other addictive substance.
    h. I am unable to keep follow-up appointments.

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date