TOWN MEDICAL CLINIC

Opioid Medications for Pain Treatment: Patient Agreement

TOWN MEDICAL CLINIC
Mullingar Healthcare Complex
Austin Friar St. Mullingar, Co. Westmeath
N91 ED2H

This Agreement is essential to the trust and confidence necessary in a prescriber/patient relationship. My prescriber has discussed my treatment plan with me. I understand that there is a risk of psychological and/or physical dependence and addiction associated with the chronic use of controlled substances for pain. I have been told about the side effects that I may experience. My prescriber is undertaking to treat me with controlled substances for pain because:

I, _____, _____ (full name, date of birth), understand and voluntarily agree to the following **(initial each statement after reviewing):**

☐ I have told my prescriber about other medications I am taking and my medical history, including my prior experience with pain medications or other drugs. Throughout my treatment, I will communicate fully with my prescriber about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to relieve pain.

☐ I will take my medication, _____, as instructed and not change the way I take it without first talking to my prescriber or other members of the treatment team. I understand that my prescriber may change this medication during my course of treatment.

☐ I will not attempt to obtain pain medications from any other prescribers. I understand that my prescriptions will be issued only during scheduled office visits with the treatment team or during regular office hours. If I require surgery or emergency treatment, and I am able to communicate, I will tell my physician about all the medications I am taking and, at or before my next refill, I will tell my prescriber about my use of medications in these circumstances.

☐ I agree not to use illegal drugs or alcohol while on these medications.

☐ I understand that I should not drive a motor vehicle or operate machinery if the medication causes dizziness, drowsiness, or sedation.

☐ I will use one pharmacy to get all my medications: _____
(Pharmacy name, phone number)

☐ I understand that I may be referred to other health care professionals for other modes of treatment, such as physical therapy, exercise, relaxation techniques or psychological counseling, or for certain diagnostic tests and that my prescriber may speak with other health care professionals about my treatment plan. At this time my treatment plan includes: _____

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☐ I will keep the medicine safe, secure, and out of reach of others, and will dispose of unused medications in a Project Medicine Drop Box, through a Take-back Program or in a drug disposal pouch.

☐ I will not sell this medicine or share it with others. If my medicine or prescription is lost or stolen, I understand that it may not be replaced.

☐ I understand that I may need to submit to random urine drug testing and pill counts if requested by my prescriber and that my prescriber will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program web site.

☐ I understand that if I do not follow all of the terms of this Agreement, my prescriber may stop prescribing pain medications, and/or that I could be required to find another prescriber or health care professional for my future medical treatment.

_____	_____	_____
Patient Signature	Patient Name Printed	Date
_____	_____	_____
Prescriber Signature	Prescriber Name Printed	Date

Note: Some agreements include the actual side effects that a patient may experience. Other provisions may be included, but are not required, such as:

☐ I will keep all my scheduled appointments including appointments for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

☐ I will not call between appointments, at night, or on the weekends looking for refills. I understand that prescriptions will be filed only during office visits with the treatment team or during regular clinic hours.