Patient Agreement For Long-Term Opioid Therapy

This agreement is based on the ***"Recommendations of the Canadian Guidelines for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain"***, which has been adopted by the College of Physicians and Surgeons of PEI. Chronic pain is pain that lasts for more than 6 months or pain that lasts longer than expected after an injury or illness.

1. **I** _____, ***agree*** that Dr. _____ will be the only physician prescribing opioid, also known as narcotic, pain medication for me and ***I agree*** that I will obtain all of my prescriptions for opioid(s) (and any other psychoactive medications) at one pharmacy location. The only exception to this will be in an emergency or the unlikely event that I run out of medication and ***I agree*** to inform any other treating physician of this agreement. ***I further agree*** to inform my physician as soon as possible should such occasion occur and to inform my physician if I am admitted to hospital. ☐

2. ***I understand*** that the use of any mood-altering substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (like cannabis, cocaine, heroin, or hallucinogens) can cause adverse effects or interfere with opioid therapy. ***I agree*** to refrain from using any of these substances without the prior agreement of my physician. ☐

3. ***I agree*** not to accept any opioid medication from any other person. ***I agree*** not to use any over the counter opioid medication, such as 222's or Tylenol#1s. ***I agree*** to check with my physician or pharmacist before taking any other over the counter medication or herb. ☐

4. ***I agree*** to take my opioid medication at the dose and frequency prescribed by my physician. I will not request earlier prescription refills. ***I agree*** not to increase the dose without first discussing it with my physician. ***I agree*** to not disrespect or harass my physician or clinic staff regarding my prescription refills. Running out of medication early, requesting early refills, escalating doses without permission and losing prescriptions could be signs of misuse of my medication and may lead my physician to discontinue my opioid therapy. ☐

5. ***I agree*** to attend all reasonable appointments, treatments and consultations as requested by my physician. ***I agree*** to participate in other chronic pain treatment modalities recommended by my physician. Chronic opioid therapy is only one part of my overall pain management plan. ☐

6. ***I agree*** to have office visits (at least every 3 months) with my physician to review my opioid therapy. ***I agree*** to bring all my unused opioid medication(s) in their original pharmacy bottles to all appointments. ***I agree*** to random, unscheduled pill counts and urine testing. The presence of non prescribed drug(s) in the urine may result in discontinuation of my opioid treatment. ☐

7. ***I agree*** to set specific, functional treatment goals, e.g., improving my ability to do things I did prior to the onset of my pain. I am aware this opioid medication will not completely eliminate my pain, but is intended to reduce it enough that I may become more functional (physically and psychologically) at home and at work, and improve my quality of life. My physician and I will continually evaluate the effect of all treatments on achieving my treatment goals. Persistent functional decline while taking opioid medication may result in re-evaluation of my opioid treatment plan. ☐

8. ***I understand*** that some of the common side effects of opioid therapy include impaired thinking, drowsiness, dizziness, impaired motor ability, nausea, vomiting, constipation, sexual dysfunction, abnormal sleep, edema, sweating and itchiness of the skin. Because drowsiness may occur when starting therapy or when increasing dosage, ***I agree to refrain from driving*** any motorized vehicle or operating dangerous machinery until drowsiness disappears and my physician agrees I am fit to drive again. Failure to comply with this advice may result in a physician's duty to report to the provincial Ministry of Transportation. Side effects can be minimized by slowly increasing the dose and by using anti-nausea drugs, stool softeners and bowel stimulants. ☐

9. ***I agree*** to be responsible for the secure storage of my opioid medication at all times, in particular to keep safe from children. ***I agree*** not to sell, lend or in any way give my prescribed opioid medication to any other person. It is illegal and could harm them. Lost, stolen or damaged opioid may not be replaced until the next ☐

regular renewal date. If my opioid medication is stolen, I will report this to police and my physician and ***I agree*** to produce a police report of this event if requested to do so.

10. ***I agree*** to use appropriate measures to prevent pregnancy during my opioid treatment and ***I certify*** that I am not pregnant at this time; because I understand if I become pregnant while taking opioids, my child will be physically dependent to the opioid and withdrawal can be life threatening for a baby. ☐

11. ***I understand*** that in an emergency situation, it is important for emergency personnel to know I am taking opioid medication and it is strongly recommended that I wear a medical alert bracelet or necklace which notes I take opioid medication. ☐

12. ***I understand*** that accidental opioid overdose is uncommon, but can be dangerous when starting or increasing the dose. Some symptoms of overdose may include impaired thinking, slurred speech, becoming upset or crying easily, poor balance, drowsiness and slowed breathing (this could result in brain damage, trauma and death). If I develop these symptoms ***I agree*** to go to the Emergency Room. ☐

13. ***I understand*** that I may develop tolerance to the opioid medication that I am prescribed. Tolerance means a state of adaption in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time. The dose of opioid may have to be titrated up or down or the prescribed opioid changed to a different one, in order to achieve maximum function and a realistic decrease of my pain. ☐

14. ***I understand*** that using long-term opioids to treat chronic pain may result in the development of a physical dependence on this medication and that sudden decreases or discontinuation of the medication will lead to symptoms of opioid withdrawal (such as runny nose, yawning, large pupils, nausea, vomiting, abdominal pain, cramps, diarrhea, aches, sweats, chills, goosebumps, altered mood, irritability) that may occur 24-48 hours after the last dose. This is a normal physiological response and though uncomfortable, it is not life threatening. ☐

15. ***I understand*** that there is a risk that I may become addicted to the prescribed opioid medication. Those at greatest risk have a personal or family history of addiction (e.g. alcohol or other drugs). ***I agree*** to inform my physician of such a history. A history of addiction does not, in most cases, disqualify me from opioid treatment for pain. Should a concern about addiction arise during my treatment, my opioid medication may need to be discontinued and I may be referred an addiction specialist. ☐

16. By signing this agreement, ***I give my physician consent*** to contact any other physician, health care provider, pharmacy, family member, legal authority or regulatory agency to obtain or provide information related to my pain management or any alleged misuse of my medications. ***I agree*** to a family, friend or significant other meeting if my physician feels it is necessary. ***I agree*** to have my medical records include information about this contract so that other physicians may be informed if necessary. ☐

I have read this agreement, understand it and have had all my questions answered satisfactorily. ***I consent to the use of opioid medication under the terms outlined in this agreement.*** *I accept full responsibility for any and all risks associated with the use of opioid therapy.* ***I understand*** *that if I break this agreement, Dr._____ may choose to cease writing opioid prescriptions for me. Withdrawal from the medication will be coordinated by my physician and may require specialist referral. In addition, my physician may choose to cease being my family physician.*

Date

Patient Name *(please print)*

Physician Name *(please print)*

Patient Signature

Physician Signature