

PATIENT TREATMENT AGREEMENTS

Sample 1. Controlled Substance Agreement

Why an agreement? The medication we are prescribing has the potential to provide much benefit, but it also can do harm to you or others. Misuse of pain medications is becoming a large problem in our community. We are doing our part to ensure that our prescriptions are taken as directed. We also want to protect you and inform you concerning the uses and abuses of this medication.

What are the benefits of opiate treatment? Opiates, also called opioids, provide relief from pain and a sense of well-being. They can allow you to perform activities that you might otherwise find limited due to pain.

What are the risks of opioid treatment? Opioids produce physical dependency with prolonged use. That means that you may experience discomfort if you discontinue these medications abruptly after taking them for over a few weeks. Some individuals have a hard time remaining medication free after being on long term opioids for that reason.

Opioids may decrease your ability to breathe deeply. This is especially true when they are combined with other sedating drugs like alcohol and some tranquilizers. This can lead to accidental overdose deaths.

Less serious side effects may include: constipation, decrease in sexual interest and performance, weight gain, sleepiness, urination difficulties, and itchiness. As with any medication, there is the rare possibility of a severe allergic reaction.

Some people are at risk of abusing these medications and may feel compelled to take them for their pleasurable effect. Therefore we are obliged to provide safeguards to protect you from these potential risks.

What are those safeguards? Our clinic has the following regulations for all patients taking long-term opioids; we will not prescribe these medications for chronic use without first:

- › Obtaining all pertinent medical records
- › Obtaining a urine drug screening (UDS)
- › Reviewing your medical condition and past history
- › Having a signed agreement between a clinician and yourself outlining the expectations of both parties.

What can I expect from the clinic? Our clinic agrees to provide you with appropriate doses of medication in a timely fashion and on an ongoing basis as long as there are no contraindications. You will be treated respectfully and professionally.

What does the clinic expect from me? The clinic expects all patients will agree to the following:

- › Agree to have only one prescriber of opioids and use only one pharmacy.
- › Bring their pill bottles to every clinic visit.
- › Have a valid phone number available to our staff, and to respond within 24 hours to the clinic if asked.
- › Agree to random urine drug screenings and random pill counts.
- › Agree to a chemical dependency or other specialist consultation should your provider feel that would be appropriate.
- › Allow open communication between this clinic and other providers concerning the use of these medications.
- › Advise other treatment providers of the medication you are taking and to inform this clinic of any health care emergencies requiring pain or anxiety treatment.
- › Agree to treat our staff respectfully and courteously.

Suggestions for safely handling your prescription: These medications can be dangerous if combined with other sedating substances. These medications are sought after by drug abusers. Therefore we ask that you follow these suggestions to provide safety for you and your medications:

- › Keep all medicines in a safe, preferably locked container, out of sight and out of the reach of children.
- › Never share these medicines with others. Never take other people’s pain medications.
- › Avoid drinking alcohol while taking these medicines.
- › Never combine these medications with other opioids or benzodiazepines (tranquilizers like lorazepam/Ativan, alprazolam/Xanax, diazepam/Valium, clonazepam/Klonopin) unless advised to by your provider.
- › Never use illicit drugs while using these medications.
- › Be aware that opioids may affect your judgment and driving skills, particularly when your dose is increasing.

How will I obtain my refills? The clinic’s policy on refills is:

- › Refill prescriptions will only be written at a clinic visit. Therefore refills will not take place over the phone, through the mail, or by calling the pharmacist.
- › All dosage changes will occur at the next clinic visit.
- › Lost or stolen medications may not be refilled until the next scheduled visit.

Will this medication relieve my pain? It is unrealistic to expect opioids to relieve all discomfort. We hope to reduce your pain so that you can regain function; that is to allow you to enjoy activities that you participated in prior to the onset of your pain. We will continue to ask that you participate in activities that improve your ability to perform daily activities. We may, in the course of your treatment, ask you to exercise, attend classes, or see a specialist of our choosing.

What are the consequences of not following these agreements? Your clinician has agreed to provide you with these medications as long as necessary, but also has the obligation to protect you and the community from abuse of these substances. In the event of suspected misuse, your provider may insist on a referral to a specialist in the assessment and treatment of drug dependency, or may immediately discontinue prescribing. Lack of improvement in function or to achieve adequate pain control may also necessitate the discontinuing of opioid medications.

I will receive my prescriptions at the following pharmacy only:

Name and phone: _____

I agree to allow the following health care facilities to share information (including any pertinent mental health, drug or alcohol history or conditions) with my provider, and to allow my health care provider to freely share pertinent health care information with these facilities for the purpose of coordinating my medical care.

Facility: _____

Facility: _____

Facility: _____

Facility: _____

By signing below I am agreeing to abide by the conditions of this agreement.

Patient’s signature: _____ **Date** _____

Person obtaining the consent: _____ **Date** _____

Sample 2. Patient/Clinic Agreement for the use of Controlled Substances

Your provider has prescribed _____ for _____ (diagnosis).

To continue receiving this medication from your provider, you are expected to follow the policies below. If you do not follow them, your provider may decide to stop prescribing the medication for you.

1. You are expected to take the medication as directed by your clinician, and to make your medication last until the next scheduled appointment. We expect our patients to be responsible for their prescriptions. You should never give any of your medications to someone else. We will not fill requests for lost or stolen prescriptions or medications.
2. Refills for controlled substances will only be done by appointment at the clinic. **We will not fill requests for controlled substances by phone, after hours, or on weekends.** We expect our patients to plan ahead to upcoming vacations, weekends and holidays and make a timely appointment if a prescription will need to be filled early.
3. By signing below you agree to submit urine or blood as requested by your provider for random drug screens. You also agree to have a working phone number where clinic staff can reach you within 24 hours. That number is _____. You agree to update the clinic anytime you move or change your phone number.
4. You agree to bring your pill bottles to each regular visit.
5. Any patient who receives controlled substances from our clinic on an ongoing basis is expected to receive these prescriptions only from our organization. If you receive additional medicines for an unanticipated injury or condition, and these are not prescribed by a our clinic provider, you are required to call the clinic the next business day, advise us of the situation and release records of the encounter to our clinic.
6. While taking narcotics or other controlled substances you are expected to refrain from misusing or abusing other drugs which could alter consciousness, impair judgment, or cause addiction, including, alcohol, marijuana, methamphetamine, or other illegal drugs. If you in any way use these medications to harm yourself, you will no longer receive them at this clinic.
7. You may be required to seek treatments or consultations you have to pay for yourself.
8. In addition to taking pain relief medication, you are expected to comply with your clinician's other recommendations for improving your pain relief, or ability to function.
9. We require you to use only one pharmacy for your refills. Your pharmacy is _____. If you decide to change pharmacies you must advise us immediately.
10. You authorize, by your signature below, any employee of our clinic to call any other health care provider, including Emergency Department staff and pharmacies, to obtain information regarding the prescription of any substance.

Your signature acknowledges you have received a copy of this agreement.

Patient Signature _____ Date _____

Print Name _____ Medical Record Number _____

The use of narcotics poses risks to patients. By prescribing _____ to you, we expect the following improvements:

- _____ Increased ability to exercise
- _____ Increased ability to participate in family activities
- _____ Increased ability to do housework
- _____ Lose weight
- _____ Able to go shopping
- _____ Able to return to work

OR _____

Alternatives to taking _____ include: _____

In addition to taking _____ to reduce your chronic pain, you are expected to:

Your allergies are: _____

The following is not necessarily a complete list of the side effects of pain medicines, but common side effects include: _____

- BRAIN** Sleepiness, difficulty thinking, confusion, slow reflexes. It is possible to be convicted of driving under the influence (DUI) if you drive while using prescribed medication.
- LUNG** Difficulty breathing or slowed breath rate to the point you stop breathing.
- STOMACH** Nausea, vomiting. Constipation can be severe.
- SKIN** Itching, rash.
- GENITO-URINARY** Difficulty urinating. These drugs reduce interest in and ability to perform sexual activities.
- ALLERGY** Potential for allergic reaction.
- TOLERANCE** With long term use, an increasing amount of the same drug may be needed to achieve the same effect.

PHYSICAL DEPENDENCE/WITHDRAWAL: Physical dependence develops within 3-4 weeks when taking these drugs. If they are stopped abruptly, symptoms of withdrawal may occur. Withdrawal can be extremely difficult and last a long time. Use of all controlled substances needs to be slowly tapered off under the direction of your prescriber.

ADDICTION: This refers to the abnormal behavior directed toward acquiring or using drugs in a non-medically necessary manner. People with a history of alcohol or drug abuse are at increased risk.

Avoid medications or substances which increase drowsiness or limit the ability to think clearly, react quickly, or which decrease your rate of breathing. Talk to your provider before taking any of these medications, even if you can buy them over the counter.

I understand these risks and agree to accept them. I will let my prescriber know of any problems or side effects I am having with this medication.

Name (print) _____

Signature _____ Date _____

Sample 3. Patient Treatment Agreement

I, _____ (patient receiving chronic pain medications), agree to correctly use pain medications prescribed for me as part of my treatment for chronic pain. I understand that these medications may not get rid of my pain but may decrease the pain and increase the level of activity that I am able to do each day. I understand that the Pain Management Clinic will deal with my chronic pain and will not deal with any of my other medical conditions.

I understand that _____ (name) will be my pain management provider and the only provider who will be ordering medications for my chronic pain.

I understand that I have the following responsibilities (initial each item you agree to):

- _____ I will only take medications at the amount and frequency prescribed.
- _____ I will not increase or change how I take my medications without the approval of my pain management provider.
- _____ I will not ask for refills earlier than agreed. I will arrange for refills ONLY during regular office hours. I will make the necessary arrangements before holidays and weekends.
- _____ I will get all pain medications only at one pharmacy. I will let my pain management provider know if I change pharmacies. **Pharmacy** _____ **Phone Number** _____
- _____ I will allow my pain management provider to provide a copy of this agreement to my pharmacy.
- _____ I will not ask for any pain medications or controlled substances from other providers and will let my pain management provider know of all medications I am taking, including non-legal drugs.
- _____ I understand that other physicians should not change doses of my pain medications made by another provider.
- _____ I will notify the Pain Management Clinic of any changes to my pain medications made by another provider.
- _____ I will let my other health care providers know that I am taking these pain medications and that I have a pain management agreement.
- _____ In event of an emergency, I will give this same information to emergency department providers.
- _____ I will allow my pain management provider to discuss all my medical conditions and treatment details with pharmacists, physicians, or other health care providers who provide my health care for purposes of care coordination.
- _____ I will inform my pain management provider of any new medications or medical conditions.
- _____ I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be replaced.
- _____ I will keep medications only for my own use and will not share them with others. I will keep all medications away from children.

In addition, I will do the following (initial each box):

- _____ I must make an appointment with a drug and alcohol counselor and bring proof of following my treatment plan.
- _____ I must take a drug test _____ (frequency).
- _____ I agree to pill counts to prove I am using my medications correctly.
- _____ If I fail a drug test, I will take the drug test _____ (frequency).
- _____ If I fail a drug test, I will be referred to Medicaid’s Patient Review and Coordination Program that restricts me to certain providers, such as a primary doctor.
- _____ If I sell my narcotics, my name will be referred to the DSHS fraud unit.
- _____ If I fail all of the above, I will be discharged from your care with no notice.

Should any of the above not show good faith efforts and my providers feel they can no longer prescribe my pain medications in a safe and effective way, I may be notified and discharged from their care.

I agree to use only the following providers. I will notify my physician of any changes in my health care and/or changes in my providers.

Provider _____ **Clinic** _____ **Phone** _____

Provider _____ **Clinic** _____ **Phone** _____

Patient Signature _____ **Provider Signature** _____

Source: Group Health, Chronic Opioid Therapy for Chronic Non-Cancer Pain Guideline, 2010.