# Model opioid patient agreement

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescriber Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Background**: Using opioid medicine is risky, and can cause overdose and addiction. From 1999 to 2014, more than 165,000 people died from overdose related to opioid pain medicine in the United States. In the past 10 years, deaths from heart attack and cancer have gone down, but death from opioid pain medication has gone up.

We used to believe that using opioids for long-term pain was safe. We now know that opioids can be harmful. Our office reviews this agreement with patients to educate about and hopefully lower harm risks. This agreement also lays out the rules for receiving opioids followed by all our providers and sites.

(Please initial the following so we know you understand each of the following.)

## Opioid medication refills

* The provider who prescribes my opioid medication is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
* I agree that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will be the only person prescribing opioids for me. I will tell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ about any other medications prescribed to me. I will tell other health care providers about opioid medications prescribed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
* I will use the same pharmacy for obtaining all medicine prescribed for my pain:

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I know that:

* Opioid prescriptions will be written for no more than 28 days.
* I must have a signed and up to date Opioid Patient Agreement, urine drug test, and state drug database check before a refill will be provided.
* I can only receive opioid medication refills between visits during business hours on Tuesdays, Wednesdays, and Thursdays.
* Refill requests will take 3 business days to process. A business day is a day that the clinic is open. For example, if I request a refill on a Thursday and the refill is granted, I can expect the refill to be ready by Tuesday of the following week.
* I will not receive a refill for a lost, stolen, damaged, or spilled opioid prescription.
* I will no longer be prescribed opioids for my chronic pain if I am arrested or put in jail related to legal or illegal drugs.

## Lowering harm

To lower the potential for harm from my opioid medication I agree that:

* I will take my opioid medication as prescribed. I will not take more than my prescribed amount without receiving instructions from my medical provider. This means I will not run out of my medication early.
* I will not share my opioid medications with anyone or sell them to anyone. This is a violation of federal law and will cause my provider to stop prescribing opioids to me.
* I agree to take only the opioid medication prescribed to me, even if another person offers me the same opioid medication, or another opioid medication that I have used in the past.
* I will not take street drugs or recreational drugs or abuse alcohol.
* I will not operate motorized equipment after beginning an opioid medication or after a change (such as a dose increase) until I know how the medicine affects me. I will not drive or operate motorized equipment if I ever feel drowsy, dizzy, or not quite myself.
* Theft or illegal use of opioid medications is common. They can even be stolen out of my home by visitors or curious young people. Therefore, I will hide or secure my opioid medications. I will consider using a lock box or another way to lock up my opioid medications.
* I will get rid of any unused opioid medications in a safe way, such as at a drop box at certain pharmacies or police departments. I can find safe drop off locations at www.takebackyourmeds.org.
* I know the clinic must notify the police if it believes there is illegal activity relating to my opioid medication, such as selling or giving away my opioid medication to other people.

## Provider-patient partnership

* I know opioid medications will not get rid of my pain completely, and the goal for treatment is to improve my day to day function. I know participating in activities I enjoy, daily physical activity such as walking, and other activities like deep breathing and mindfulness meditation can be as or more effective than opioid medication.
* I agree to tell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of any over-the-counter drugs, vitamins, and herbal medicines I am taking.
* I agree to tell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ within 48 hours if I have a drug overdose.
* I agree to random urine/blood screening (drug testing) at any time during treatment.
* I know I must schedule and attend all scheduled follow-up appointments. If I cannot come, I will call at least 24 hours in advance to reschedule my appointment.
* I know any verbally or physically threatening abusive behavior toward providers or staff will lead to no further refills of my opioid medication.
* I know other doctors, pharmacists, and/or other health workers can report any suspected violations of this agreement to my medical provider.
* I know my provider may stop prescribing opioid medication if I do not follow this agreement.

By signing below, I agree that I have read and understood the above. Any questions I have about this agreement have been answered to my satisfaction. If I am not able to keep the promises made in this agreement, I will inform you. I understand that if I do not follow this agreement, my provider can choose to stop providing my opioid medication treatment. If this occurs, I understand that the clinic will let me know this in person or at my last known address or phone number.

Patient/legally authorized representative signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescribing Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_