OPIATE SUBSTANCE AGREEMENT

In the event that you may be prescribed opiate/controlled substance medications for pain management, the following contract must be completed.

The purpose of this agreement is to prevent misunderstandings about certain medications you will be taking for pain management. In initialling the following statements, you agree to the terms and conditions set forth herein the Opiate/Controlled Substance Agreement between yourself and your physician at the CHRONIC PAIN TREATMENT CENTRE

Patient Name: _____ Date of Birth: _____

Please initial against each of these terms and conditions:

- _____ I understand that only my pain doctor/prescriber at the CHRONIC PAIN TREATMENT CENTRE will prescribe opiate/controlled substance medications for me, unless otherwise agreed with by my pain doctor.
- _____ In this case, my medications will be tapered over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.
- _____ I will not use any illegal controlled substances such as cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to time when I am not driving, operating machinery and will be infrequent.
- _____ I will not share my medication with anyone.
- _____ I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other doctor without informing or the consent of my main prescribing doctor. Should I receive prescriptions of opiates or benzodiazepines (valium, ativan) from another physician I am obligated to notify my prescriber.
- _____ I will safeguard my pain medication from loss or theft. I understand that **LOST OR STOLEN MEDICATIONS WILL NOT BE REPLACED**.
- _____ I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours.
- _____ I agree that I will submit to a blood or urine test if requested by my prescriber to determine my compliance with my program of pain control medications.
- _____ I agree that I will use my medicine at a rate no greater that the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
- _____ I agree to follow these guidelines and all of my questions and concerns regarding treatment have been adequately answered.
- _____ I understand that if I break this Agreement, my prescriber will stop prescribing these pain control medicines.

Name of your pharmacy: _____

Pharmacy address: _____

Pharmacy phone number: _____

I _____, agree to use the above stated pharmacy only for filling my prescriptions for all of my pain medicine. This Agreement is entered into on _____ (date).

Patient signature: _____ **Witnessed by:** _____