Hand In Hand HOSPICE

Pain Management/Opioid Treatment Agreement

1. I, _____, understand that my physician, Hand in Hand Hospice and myself, will work together to find the most appropriate treatment for my chronic pain. I understand the goals of treatment are not to eliminate pain, but to partially relieve my pain in order to improve my ability to function. Chronic opioid therapy is only ONE part of my overall pain management plan.

2. I will communicate fully with my primary nurse and/or physician about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

3. I understand that my provider and I will continually evaluate the effect of opioids on achieving the treatment goals and make changes as needed. I agree that I will use my medicine at a rate no greater than 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. During this time I may have symptoms of withdrawal related to abstinence. I understand that if my prescription runs out early for any reason (for example, if I lose the medication or take more than prescribed), my provider will not prescribe extra medication for me. I will have to wait until the next prescription is due.

4. I agree that I will submit to a medication count at any time if requested by my provider/nurse to determine my compliance with any program of pain control medicine.

5. I will not seek opioid medications from another physician for the treatment of my chronic pain. Regular follow-up care is required and only my provider will prescribe these medications for my chronic pain.

6. I will not attempt to obtain controlled medicines, including opioid (narcotic) pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor; or from acquaintances, friends, or relatives. I will only obtain my medications from one pharmacy.

7. I will attend all appointments, treatments, and consultations as requested by my providers. I will attend all pain appointments and follow pain management recommendations made by my physician and/or Hospice nurse.

8. I will not give or sell my medication to anyone else, including family members. I agree to be responsible for the secure storage of my medication at all times. If these medications are stolen, Hand in Hand Hospice will report this to the police and to the prescribing provider.

9. I understand that the use of other medications can cause adverse effects or interfere with opioid therapy. Therefore, I agree to notify my provider of the use of all substances, including marijuana, alcohol, medications not prescribed for me (tranquilizers), and all illicit drugs.

10. I understand that I will consent to random drug screening. A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.

11. I understand that my failure to meet these requirements may result in my provider choosing to stop writing opioid prescriptions for me.

12. I hereby agree that my provider has the authority to discuss my pain management with other health care professionals and my family members when it is deemed medically necessary in the provider's judgment.

13. My providers may obtain information from State controlled substances databases and other prescription monitoring programs.

Patient Name (printed)	Patient Signature	Date

Power of Attorney/Authorized Representative Signature	Date	Relationship to Patient

Pharmacy Name

Hospice Representative	Date

References/Resources cited:https://opioids911.org/media/doc/Op911-OpioidRxAgreements.doc
http://theothermedicalclinic.com/paintopics/paincontract.html