UMassMemorial

Place name sticker or stamp with card

OPIOID PAIN MEDICATION AGREEMENT

To help in getting my long standing pain in better control, and to help me reach the goals I have set (*see pain goals*), opioid pain medication is being prescribed for me. In order to make this medication safe and follow national and state laws, I _____ understand that:
(*patient's name*)

–This medication may not take away all my pain.
–I should follow the directions given to me by my health care provider. I will not take more than what I am told to take.
–There are side effects of this medication described to me by my health care provider. All my questions about this medication have been answered.
–I will call my health care provider's office if I am having side effects after starting this medication.
–This medication may make me sleepy. Driving or operating machinery while taking this medication can be dangerous.
–Taking alcohol or street drugs along with this medication is dangerous.
–My body may get used to the medication and if I stop it too quickly I could get sick.
–Some people have become addicted to these medications. If I think this is happening to me I will speak to my health care provider.

Patient's Signature _____ **Date** _____

I _____ agree:
(*patient's name*)

–To obtain pain medication only from the health care provider signed below, or his/her medical team, and to notify my provider immediately if I obtain any pain medication from an emergency room.
–Only to get pain medication during regular office hours and not to call after office hours for pain medication.
–To fill my medications only at one pharmacy which is _____
–To give urine samples and to bring in my pills to be counted whenever asked of me.
–Not to use illegal drugs along with this medication.
–Not to sell or give away my medication.
–To keep my medication safe. If it is lost or stolen I understand it may not be replaced.
–To allow my health care provider to exchange information with people who might need to know about my medication use if he/she thinks it is necessary for my health and safety.
–To keep all of my health care appointments recommended to me to treat my pain.
–That my medication can be stopped at any time, after a discussion with my health care provider.

Patient's Signature _____ **Date** _____

I _____ agree:
(health care provider's name)

–To explain your pain condition and how opioids are expected to help.
–To explain the risks, side effects and alternatives to opioid treatment.
–To monitor your pain level at each visit to help assure good pain control and help meet your goals (*see goal sheet*).
–To continue to change the plan for pain control as needed to get good control of pain.
–To include a pain specialist, and/or other health care specialists *(such as Behavioral Health, Physical Therapy, Massage Therapy, Acupuncture and Osteopathic Manipulation)* in your care, as needed to reach your goals.
–To keep you safe, to the best of my abilities, while you are taking opioid medications. I will provide help should you become addicted.

Health Care Provider's Signature _____ **Date** _____