# 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:

- 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** ______________________

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I agree:

- 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** ______________________

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I agree:

- 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** ______________________