



**Patient Contract  
for  
Using Opioid Pain Medication in Chronic Pain**

This is an agreement between \_\_\_\_\_ (the patient) and Dr. \_\_\_\_\_ (the doctor) concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of a chronic pain problem. The medication will probably not completely eliminate my pain, but is expected to reduce it enough that I may become more functional and improve my quality of life.

1. I understand that opioid analgesics are strong medications for pain relief and have been informed of the risks and side effects involved with taking them.
2. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable, but not a life-threatening condition.  
  
I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids and withdrawal can be life-threatening for a baby.
3. Overdose on this medication may cause death by stopping my breathing; this can be reversed by emergency medical personnel if they know I have taken narcotic pain-killers. It is suggested that I wear a medical alert bracelet or necklace that contains this information.
4. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.
5. I understand it is my responsibility to inform the doctor of any and all side effects I have from this medication.
6. I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. Running out early, needing early refills, escalating doses without permission and losing prescriptions may be signs of misuse of the medication and may be reasons for the doctor to discontinue prescribing to me.
7. I agree that the opioids will be prescribed by only one doctor and I agree to fill my prescriptions at only one pharmacy. I agree not to take any pain medication or mind-altering medication prescribed by any other physician without first discussing it with the above-named doctor. I give permission for the doctor to verify that I am not seeing other doctors for opioid medication or going to other pharmacies.
8. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced.
9. I agree not to sell, lend, or in any way give my medication to any other person.
10. I agree not to drink alcohol or take other mood-altering drugs while I am taking opioid analgesic medication. I agree to submit a urine specimen at any time that my doctor requests and give my permission for it to be tested for alcohol and drugs.

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- 11. I agree that I will attend all required follow-up visits with the doctor to monitor this medication and I understand that failure to do so will result in discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities recommended by my doctor.
- 12. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.

I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the doctor may discontinue this form of treatment.

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Patient signature

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Doctor signature

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Date

Addendum:

I understand that the medication is prescribed as follows:

Type of medication \_\_\_\_\_

Number of pills and frequency \_\_\_\_\_

Total number of pills \_\_\_\_\_

Next refill due \_\_\_\_\_

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Patient signature

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Doctor signature