PREMIER ORTHOPAEDIC
BONE & JOINT CARE

Opioid Pain Management Agreement

The purpose of this agreement is to prevent misunderstanding about certain medications you will be taking for pain management. This agreement is to help you and your provider comply with the law regarding controlled Pharmaceuticals.

____ I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

Risks associated but not limited to:

- Sedation may interfere with your ability to drive and operate machinery safely.
- Interfere with breathing, which could become life threatening, urinary and bowel function.
- The potential for addiction, abuse, and misuse.
- Nausea, vomiting, itching, mood changes, muscle twitching, and allergic reactions.
- Injury to fetus and unborn child in pregnant women.
- Overdose as a result of accidental exposure. (especially in children)
- Sweating, edema, sexual dysfunction and skin rashes.

Physical dependence is an inevitable consequence of chronic opioid use. This involves the body becoming used to having medication present. If someone who is physically dependent on a medication discontinues the use of that medication suddenly, he or she may experience an uncomfortable withdrawal syndrome.

Addiction is not the same as a physical dependence, although the two may overlap. Addiction involves the compulsive use of a substance, against a provider's instructions, for the unintended purposes. It may also involve unauthorized increases in the medication.

____I understand that if I break this agreement, my provider will stop prescribing these controlled pain medications.

____I will not use any illegal controlled substances, including marijuana, cocaine, ETC., nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to times I am not driving or operating machinery and will be infrequent.

____I will not share my medication with anyone.

____I will not attempt to obtain any controlled medications from another provider.

____I will safeguard my pain medication from loss, theft, or unintentional use by others, including youth. Lost or stolen medications will not be replaced.

____I agree that all my refills of my pain medications will be made when the office is open. No refills will be available on nights or weekends.

____I agree to submit to a blood or urine test if requested by my provider to determine any compliance.

____I understand that my provider will be verifying that I am receiving controlled substances from only one provider and only one pharmacy by checking the Prescription Monitoring Program website periodically throughout my treatment.

____I agree to use pharmacy _____ located in the town of _____

for filling my control prescriptions.

____I authorized the provider and pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the state's board of pharmacy. I authorize my doctor provide a copy of this agreement to my pharmacy, primary care physician, and local emergency rooms. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

____All of my questions and concerns regarding treatment have been adequately answered. A copy of this agreement has been offered to me.

This agreement is entered into effect on ____/____/_____

Patient Name (PRINTED): _____

Patient Signature: _____

Date: _____/_____/_____

Provider Name (PRINTED): _____

Provider Signature: _____

Witnessed by (PRINTED): _____

Witness Signature: _____