

# Patient-Provider Agreement for Long-Term Controlled Medicines for Chronic Pain

I, _____, and _____ <b>(Patient)</b> <b>(Provider)</b>
have decided to use controlled medicines to treat: _____ <b>(symptom, cause)</b>
Medications prescribed (name, dose, directions, frequency of dispensing):
1 _____
2 _____
3 _____

## Purpose

The purpose of this agreement is to make clear what I can expect when I am prescribed controlled medicines (like codeine, fentanyl, methadone, morphine, oxycodone, Percocet, Vicodin) as part of the treatment of my pain. It describes what I can expect from my provider and what my provider expects of me.

## My Provider's Responsibilities

It is my provider's responsibility to assess my pain and to create and monitor a treatment plan that is safe and appropriate for my condition. My provider is also responsible for making sure that my treatment follows the law about controlled medicines. This includes making sure that I do not misuse the medicines that are prescribed for me and/or that others do not get a hold of or use my medicines.

## My Responsibilities

I, \_\_\_\_\_ understand and agree to the following:  
**(Patient)**

- My treatment plan may include other things besides medications like: diagnostic tests, group visits or specialty visits. I agree to follow the treatment plan that my provider and I have agreed to.
- Only I will take these medicines. I will not share, give away, lend, sell or trade these medicines. I will not let others use my medicines.
- I will only take these medicines as directed.
- My prescriptions may not be refilled early. I may run out of medicines if I take more than my provider tells me to.
- I can only refill prescriptions during regular clinic hours and according to the refill policy of my clinic.
- I will guard my medicines like my money or jewelry. Lost, stolen or damaged medicines or prescriptions may not be replaced.
- I will not seek controlled medicines from other places without talking to my provider. This includes urgent care and the emergency department. I will tell my provider right away if I get a prescription for other controlled medicines.
- My pharmacy records may be reviewed.

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- I will behave respectfully towards all staff. I will not be abusive or rude.
- I have been advised not to use illegal drugs or unprescribed controlled medicines. I will be asked to do urine testing for drugs at least yearly, and perhaps more often.
  - If my drug test shows illegal drugs or unprescribed controlled medicines, my medicines may be stopped or I may need to go to substance use treatment in order to continue getting controlled medicines.
  - If my drug test does not show that I am using my prescribed medicines, my provider may stop these medicines.
- Any medical treatment starts on a trial basis. My prescription may be stopped. This would happen if there are no signs that the medicines are helping me or if there are signs of harm or misuse.
- I will talk to my provider if I am pregnant or want to get pregnant.
- I will tell my provider if I am taking other medicines.
- I will tell my provider about my personal and family history of addiction or substance use.
- I understand the possible risks and benefits of these medicines.
- Other Terms:
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
- If I break this agreement, my provider may stop prescribing controlled medicines for me.
- This agreement will be reviewed at least once a year. It may also be reviewed if I change providers or break the agreement.

**I understand this form. I have been able to ask questions about this agreement and have them answered. I have been offered a copy of this form.**

I am signing this form because I want to. I accept all of its terms.

Patient: **X** \_\_\_\_\_

Provider: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_