PATIENT – PHYSICIAN CONTRACT

1. I, _____ agree that Dr. _____ will be the only physician prescribing OPIOID (also known as NARCOTIC) pain medication for me and that I will obtain all of my prescriptions for opioids at one pharmacy _____. The exception would be an emergency situation or in the unlikely event that I run out of medication. Should such occasions occur, I will inform my physician as soon as possible.

2. I will take the medication at the dose and frequency prescribed by my physician, I agree not to increase the dose of opioid without first discussing it with my physician

3. I will attend all reasonable appointments, treatments and consultations as requested by my physician.

4. I understand that the common side effects of opioid therapy include nausea, constipation, sweating and itchiness of the skin, Drowsiness may occur when starting opioid therapy or when increasing the dosage. **I agree to refrain from driving a motor vehicle or operating dangerous machinery** until such drowsiness disappears and my doctor agrees that I am fit to drive again.

5. I understand that using long-term opioids to treat chronic pain may result in the development of a physical dependence on this medication, and that sudden decreases or discontinuation of the medication will lead to the symptoms of opioid withdrawal, I understand that opioid withdrawal is uncomfortable but not life threatening.

6. I understand that there is a small risk that I may become addicted to the opioids I am being prescribed. As such, my physician may require that I have additional blood, urine or hair testing and/or see a specialist in addiction medicine should a concern about addiction arise during my treatment.

7. I understand that the use of any mood-modifying substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid therapy, Therefore I agree to refrain from the use of all of these substances without prior agreement from my physician,

8. I agree to be responsible for the secure storage of my medication at all times. I agree not to give or sell my prescribed pain medication to any other person. Depending on the circumstances, lost medication may not be replaced until the next regular renewal date.

9. By signing this agreement I waive my right of privacy and give my doctor consent to contact any other health care provider, pharmacy, legal authority, or regulatory agency to obtain or provide any information related to my pain management or any misuse of my medications.

10. I understand that if I break this agreement, my physician reserves the right to stop prescribing opioid medications for me.

Date: _____

Patient Signature: _____ **Physician Signature:** _____