

**Patient Treatment Agreement**  
**For Use of Controlled Substances in Treating Chronic Pain**

The purpose of this agreement is to inform me about the use of pain medications and to ensure that I and [PHYSICIAN NAME] comply with all state and federal regulations concerning the prescribing of controlled substances. My compliance with this agreement is necessary to ensure that [PHYSICIAN NAME] can effectively prescribe opioids and other medication to decrease my pain and provide an improved quality of life.

The success of my treatment depends on mutual trust and honesty in the physician/patient relationship, full understanding of the risks and benefits of using controlled substances to treat pain, and my compliance with the opioid treatment plan provided by my physician.

I understand and agree to the following terms and conditions in connection with my pain treatment:

1. Prescription of opioid medications will begin as a trial and continued prescription is contingent on evidence of benefit. If function and activities of daily living do not improve, I understand that opioid prescriptions will cease. The goal of opioid treatment is to decrease my pain, but it may not take away my pain completely.
2. [PHYSICIAN NAME] will document the expected outcomes of my treatment in my medical record, which I may request at any time.
3. I have been made aware of and given the opportunity to discuss alternative treatments that do not involve the use of opioids or other medications, including their benefits and risks. The alternative treatments discussed were: \_\_\_\_\_  
\_\_\_\_\_
4. I have discussed with [PHYSICIAN NAME] a strategy for discontinuing opioid treatment in the event they are ineffective at treating my pain.
5. I understand that [PHYSICIAN NAME] will regularly evaluate me for opioid use disorder and, if necessary, will provide specific treatment or refer me to another provider for evaluation or treatment.
6. Common side effects of opioid therapy may include, but are not limited to, drowsiness, dizziness, skin rash, constipation, nausea, itching, vomiting, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, depression, impaired cognitive (mental) status, and impaired reflexes or motor control. Overuse or abuse of opioids can decrease respiration (breathing), which may lead to death. Specific potential side effects that might affect me in connection with opioid treatment include : \_\_\_\_\_  
\_\_\_\_\_
7. I may become addicted to these medications and require addiction treatment. I recognize that treatment of pain with opioids may increase the possibility of relapse of alcohol or drug misuse/addiction. Anyone can develop an addiction to opioid pain medications, but people who have existing or former mental illness or drug or alcohol addiction are at a higher risk. I have told my provider if I or anyone in my family has a history of mental illness or addiction. A history of addiction does not disqualify me from opioid treatment of pain but starting or continuing a program for misuse/addiction recovery may be necessary.

8. Additionally, males and females may experience specific side effects:
  - a. **Females:** Opioid use while pregnant will result in the baby's physical dependency upon opioids. Opioid use while pregnant is not generally associated with a risk of birth defects; however, there is always the possibility that the baby will have a birth defect while the mother is taking opioids. Therefore, I will immediately call my obstetric doctor and [PRACTICE NAME] if I plan to become pregnant, or believe that I may have become pregnant, while taking pain medicine.
  - b. **Males:** Chronic opioid use has been associated with low testosterone levels in males. This may affect mood, stamina, sexual desire, and physical and sexual performance. Therefore, my doctor may test my blood testosterone levels.
9. Due to these potential side effects, I will not participate in any activity that may be dangerous as a result of slowed reflexes and reaction time while under the influence of opioids or other medication. This includes operating machinery or automobiles, working in unprotected heights, and providing care for another who is unable to care for herself or himself.
10. In addition to addiction, physical dependence and/or tolerance can occur with the use of opioid medications:
  - a. **Physical Dependence** means that if the opioid medication is abruptly stopped or not taken as directed a withdrawal symptom can occur. This is a normal physiological response. The withdrawal symptom could include, but is not limited to, sweating, nervousness, abdominal pain and cramping, diarrhea, goose bumps, aches, irritability, and mood alteration. Physical dependence is not the same as addiction.
  - b. **Tolerance** means a state of adaptation in which exposure to the drug results in the drug's effects over time. The dose of the opioid may have to be increased or decreased to a dose that produces maximum function and a realistic decrease to the patient's pain.
11. I understand that other medications and substances may affect the results of opioid therapy, including over-the-counter medications and alcohol. Some medicines may even reduce the effectiveness of the opioids I am taking for pain control. Taking too much of my pain medication, or mixing my pain medications with drugs, psychiatric medicine, or other medications that cause sleepiness, such as benzodiazepines, barbiturates, and other sleep aids, could cause me to be dangerously sedated or to overdose and stop breathing.
12. I will notify [PHYSICIAN NAME] of any medications I am currently taking and I will notify other physicians that I am taking opioid pain medication. I will inform [PRACTICE NAME] within 24 hours of receiving a pain prescription from any other health care provider. For example, this may occur if I have surgery or visit the emergency room.
13. [PHYSICIAN NAME] will periodically query reports regarding my opioid prescription history from Virginia's and other states' Prescription Drug Monitoring Programs.
14. I understand that [PHYSICIAN NAME] will closely monitor my Morphine Milligram Equivalents (MME) per day which may require referrals to other providers. I may be prescribed naloxone, a medication designed to reverse the effects of opioids and other medications. I also understand that I can purchase naloxone without a prescription at many pharmacies.
15. I agree to fully communicate the following information to [PHYSICIAN NAME] to allow for adjustment of my treatment plan:
  - a. the nature and intensity of my pain;
  - b. current and past treatments for pain;

- c. underlying or coexisting diseases or conditions;
- d. the effect of pain on my physical and psychological function and quality of life;
- e. my or my family's psychiatric, addiction, and substance abuse history;
- f. any side effects of the medications.

16. I will not use any illegal substances, such as cocaine, marijuana, etc., while taking opioid medications prescribed by [PHYSICIAN NAME]. I understand that I should not drink alcohol while taking opioids.
17. [PHYSICIAN NAME] reserves the right to perform unannounced urine or blood testing. Inconsistent test results, including the failure of a prescribed drug to be in my urine or blood, or the presence of a non-prescribed drug or illegal drug in my urine or blood is grounds for termination of the physician/patient relationship and referral for assessment for addictive disorder.
18. Evidence of drug hoarding, acquisition of pain medication from other physicians (including emergency departments), unapproved dose alteration, loss of prescriptions, any non-compliance, or failure to follow this agreement may result in termination of the physician/patient relationship.
19. I may not share, sell, or otherwise permit any other person access to my medications. Doing so may endanger that person's health. It is also illegal. I will protect my medications from loss or theft. Therefore, I will keep my pain medications in a safe and secure place, such as a locked cabinet. [PHYSICIAN NAME] discussed with me methods for proper disposal of unused opioids.
20. Prescriptions for pain medications will only be written during an office visit. I will see [PHYSICIAN NAME], at a minimum, every 90 days, and receive prescriptions sufficient to last until the next appointment. Refills will not be provided between office visits, over the phone, during the evening, or on weekends.
21. An exception may be granted if my prescription or medication has been stolen and I complete a police report regarding the theft; or if I or [PHYSICIAN NAME] will be unavailable when a refill is due. In the latter case, [PHYSICIAN NAME] may prescribe refills in advance of a regularly-scheduled visit but the prescriptions will instruct the pharmacist not to fill them prior to a specific future date.
22. I agree to allow [PHYSICIAN NAME] to communicate with any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care, actions, or prescription history.
23. I will use only one pharmacy to fill pain prescriptions, unless impossible. I will notify [PRACTICE NAME] if I must switch pharmacies. The pharmacy I have selected is—  
Name of Pharmacy: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_

Violating any of the above conditions may result in termination of the physician/patient relationship. A patient will be given written notice of dismissal that she/he has 30 days to find another physician to provide opioid therapy. After this time period, the patient will no longer receive any controlled substances or other pain medication from [PRACTICE NAME].

The above agreement has been explained to me by [PHYSICIAN NAME] and [PHYSICIAN NAME] satisfactorily answered all of my questions regarding this treatment. I understand all of it and I voluntarily consent to its terms.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Name (Printed) \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_