

Patient Information:

MRN:

DOB:

PAIN MANAGEMENT AGREEMENT

Pain Management Agreement Between _____ (patient)
MRN # _____ and _____ (MD/NP)

The purpose of this Agreement is to prevent misunderstandings about certain medicines the patient will be taking for pain management. This is to help both the patient and their provider comply with the law regarding controlled medications.

This agreement relates to my use of controlled substance for chronic pain prescribed by a physician at the UC Health Pain Management Center. I have been informed and understand the policies regarding the use of controlled substance that are followed by the staff at the UC Health Pain Management Center. I understand that I will be provided controlled substance while actively participating in this program only if I adhere to the following conditions:

1. I understand that my provider and I will work together to find the most appropriate treatment for my chronic pain. I understand the goals of treatment are not to completely eliminate pain but to control my pain in order to improve my ability to function. Chronic Opioid therapy is only ONE part of my overall pain management plan.
2. I understand that my provider and I will continually evaluate the effect of opioids on achieving the treatment goals and make changes as needed. I agree to take the medication at the DOSE and **FREQUENCY** prescribed by my provider. I agree not to increase the dose of opioids on my own and understand that doing so may lead to the discontinuation of opioid therapy.
3. I will attend all appointments, treatments and consultations as requested by my providers. I will attend all pain appointments and follow pain management recommendations. I understand that failure to keep appointments may lead to discontinuation of treatment.
4. I will tell my providers about the level and description of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve my pain.
5. I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy, behavioral medicine, and other pain control strategies. I agree to cooperate and actively participate in all aspects of the pain management program to maximize functioning and improve coping with my condition.

If treatment for my condition is available, I agree I will not refuse the treatment just so the (O)plains will be continued. I understand that I have the right to refuse any procedure, but that does not mean that my provider must continue to prescribe narcotic or opioids medications.

Patient Information:

MRN:

DOB:

PAIN MANAGEMENT AGREEMENT

6. The risks and benefits of taking opioid medications have been explained to me. I understand them. Opioids can cloud judgments and affect reflexes and motor skills. The patient will not participate in activities that would endanger themselves or others while using these medications.
7. I agree I will not use any illegal controlled substances, including marijuana, cocaine, Heroin, etc. I agree I will not use any prescription medications obtained illegally, or obtain them from friends or relatives.
8. I agree I will not abuse alcohol. If my provider advises, I will not use any alcohol.
9. I agree I will not share, sell or trade my medication with anyone.
10. I agree to protect my pain medicine from loss or theft. Lost or stolen medicines will not be replaced. I will report stolen medication to the police and to my provider and will produce a police report of this event.
11. I agree I will not attempt to obtain any opioid medicines from another doctor or provider without informing the UC Health Pain Management Center doctor/nurse practitioner first. I agree to have my opioid prescriptions filled only at _____
12. I agree that refills of my prescriptions for pain will be made only at the time of an office visit or during regular office hours. No routine refills will be available during evenings, after 4 pm, or on weekend, holidays, or through the emergency room. Medications will not be mailed or refilled without being seen at monthly pain clinic appointment (if patient is receiving his opioids from the pain clinic).
13. I am responsible for keeping track of the amount of medications left and to plan ahead for arranging the refill of my prescriptions in a timely manner so I will not run out of medications.
14. I agree to bring in all unused pain medicine when requested.
15. I will submit urine for drug testing if requested by my provider to determine my compliance with their program of pain control.
16. I authorize the UC Health Pain Management Center to cooperate fully with any official, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine.
17. I will accept generic brands of my prescription medications.

Patient Information:

MRN:

DOB:

PAIN MANAGEMENT AGREEMENT

18. I understand that I may become tolerant to, addicted to or have complications from the opioid medications. If this occurs, the medication may be changed or tapered and other methods of pain control may be used. If necessary, I will permit referral to addiction specialists.

19. If it appears to the physician that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will agree to gradually taper my medication as directed by the prescribing physician.

20. I understand that if I violate any of the above conditions, my provider may choose to stop writing opioids prescribed for me. Discontinuation of the medications will be coordinated by the provider and may require specialist referrals.

21. I understand that if I am verbally or physically abusive to any staff member or engage in any illegal activity such as altering a prescription, that the incident may be reported to other physicians, local medical facilities pharmacies and other authorities such a the local police department, drug enforcement Agency, etc. as deemed appropriate for the institution.

22. Understanding that suddenly stopping some pain medicines can cause problems such as:
 withdrawal symptoms
 heart attack
 stroke
 seizures
 permanent damage
 disability or death.

UC Health Pain Management Center
7700 University Court Suite 3200 West Chester, OH 45069
513-751-PAIN Fax: 513-475-8283

DATE:
TIME:
Page 4

Patient Information:

MRN:

DOB:

PAIN MANAGEMENT AGREEMENT

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

Medication Refill information:

1. Advance notice of 5-7 business days is required for all **non-opioids** refills of the prescriptions
2. Requests for scheduled refills for **non-opioids** must be telephoned to the pharmacy only during regular office hours Monday-Friday (8:30 am – 4:00 pm). Refills will not be made at night, on holidays, or on weekends.
3. Most controlled substance can not be telephoned in to the pharmacy.
4. I will be given a (30) thirty days supply each month.
5. All hard copies of the opioids prescriptions must be hand delivered to the pharmacy by myself

⟨ **This agreement will supersede all other agreements**

⟨ By signing below I indicate that I understand AND agree to ALL the terms of the above agreement. I have received a Copy of this for my own records.

Patient _____ Signature

Witness _____ Signature

Provider _____ Signature

Date _____