Example Pain Agreement Provided by East Greenwich Spine & Sport and available at: http://www.egss.us/resources/

Controlled Substances Policy and Agreement

This is an agreement between _____ (patient) and _____ (prescribing provider) concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of pain. To comply with state and federal regulations, East Greenwich Spine and Sport has developed the policy outlined in this agreement regarding the use of opioid analgesics. By signing this agreement, I am stating that I understand the risks and benefits of this class of medication as well as the policies of this practice regarding its use and agree to abide by these policies.

The medication will probably not completely eliminate my pain, but the expected **benefit** is to reduce it enough to improve my quality of life at home and at work. Research has shown that opioid analgesics will relieve pain by 30% on average, but will not improve function.

I understand that the following are **risks** associated with the use of opioid analgesics and will immediately alert the prescribing provider should any occur:

- Nausea, constipation and decreased appetite
- Problems with urination and problems with sexual function (men and women)
- Irregularity of menstrual periods
- Confusion, impaired memory and problems with concentration
- Depression, panic attacks and other mood changes
- Insomnia
- Sleepiness, drowsiness and problems with coordination or balance; making it unsafe to drive or operate machinery while using these medications.
- Difficulty breathing
- Allergic reaction (anaphylaxis) causing rash, hives or difficulty breathing; if left untreated this could lead to death.
- Addiction: a chronic preoccupation with obtaining a substance, misuse of a substance despite negative consequences, and propensity for obtaining a substance through illegal means or use of other illegal substances to satisfy a need or craving.
- Physical dependence: a physiological state of adaptation to a specific opioid (pain medication) leading to a withdrawal syndrome (nausea, vomiting, diarrhea, cramps, aches, sweating and chills) during abstinence, which may be relieved totally or in part by re-administration of the substance.

These risks are much higher and more severe if opioids are used together with other narcotics, alcohol, marijuana, cocaine, stimulants, depressants, hallucinogens or mood altering drugs.

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I understand and agree to the following **policies** of East Greenwich Spine and Sport regarding the use of opioid analgesics:

1. I agree to obtain opioid prescriptions from one provider and only one provider. The prescribing provider is _____ I understand that if there is evidence of opioid medications being obtained or requested from another source, no further prescriptions will be written and I will be discharged from the practice.

2. I agree to fill my prescriptions at one pharmacy only. The pharmacy is: _____

3. I will communicate with other providers who are treating me that I am under a controlled substance agreement with the prescribing provider.

4. I consent to release this agreement information to other providers, emergency departments, pharmacies and consultants and to allow pharmacies to release my prescription history. I also consent or other providers, emergency departments, pharmacies and consultants to report violations of this greement to the prescribing provider and my primary care provider.

5. Each prescription will be written for a fixed amount of medication sufficient to last until the next visit. I agree not to change the dosage of my narcotic medication. Dosage changes will be made only during office visits with the prescribing provider. I understand that making my own changes in dosing are grounds for discontinuation of the medication and dismissal from the practice.

6. I agree not to use alcohol or any illegal substances (narcotics, marijuana, stimulants, depressants, hallucinogens or mood altering drugs) while under this agreement.

7. I agree to follow up with recommended consultations, studies, X-rays, physical therapy, counseling and laboratory testing including random blood or urine drug testing. If I should fail to follow up with recommended testing or have a positive urine drug test, then the prescribed medication will be tapered and discontinued. If I have a positive urine drug test and agree to attend a drug rehab program, I may continue to be followed as a patient at East Greenwich Spine and Sport but will not be prescribed narcotics.

8. I understand that it is my responsibility to keep the medication in a secure place. If my medications are damaged, lost or stolen, I understand that they will not be replaced. If medications are stolen, a police report will be given to the prescribing provider and become a part of my medical record.

9. I understand that if the prescribing provider or my primary care provider become concerned that there is illegal activity; he or she may notify the proper authorities including law enforcement.

10. Prescriptions will not be refilled or adjusted over the phone. Adverse reactions to prescribed medications should be reported to the office, which may result in change in dosage or discontinuation of medication.

11. I understand that I can reduce the use of medications by leading a healthy lifestyle and will work with my provider to optimize my overall health. This may include regular exercise, diet changes, quitting smoking and other lifestyle modifications.

12. The terms of this agreement will end with the termination of prescribed opioid analgesics by the prescribing provider.

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I have read and discussed with the prescribing physician the above agreement and terms for use of opioid analgesics as they pertain to my care. All of my questions about opioid use and the policies of this practice have been answered to my full satisfaction. I consent to treatment with opioid analgesics according to the policies of _____.

Patient signature _____ Date_____

Provider signature _____ Date_____

Witness signature _____ Date_____

Primary Care Provider:

In an attempt to keep lines of communication open and provide a coordinated care plan for your patient, we ask you to review and sign the following. The providers at East Greenwich Spine and Sport will remain available for questions and follow-up as needed after patients are returned to their respective Primary Care Provider.

- I am the Primary Care Physician for the above named patient.
- I am familiar with the opioid policy at East Greenwich Spine and Sport and believe opioid medications may be appropriate for this patient.
- I agree to assume responsibility for his/her opioid prescriptions once a stable dose has been determined and monthly visits are no longer necessary at East Greenwich Spine and Sport.

Primary Care Physician's Signature_____Date_____

Name printed: _____

Address: _____

_____

Phone: _____