Patient-Prescriber Agreement

_____ I understand that the goal of treatment is not to eliminate pain completely, but to relieve pain in order to improve my ability to function.

_____ I understand that my provider and I will continually evaluate the effect of opioids on achieving my treatment goals and make changes as needed.

_____ I understand that opioids may cause constipation, nausea, sweating, itchiness, swelling, sedation, and impaired cognitive or motor ability.

- I agree to refrain from driving a motor vehicle or operating dangerous machinery.
- I understand that the overuse of opioids can cause breathing problems.

_____ I understand that physical dependence and/or tolerance may occur

- Physical dependence is a normal physiologic response to opioids and is NOT addiction; as a result, stopping treatment abruptly can cause withdrawal symptoms such as sweating, nervousness, abdominal cramps, diarrhea, goosebumps, and/or mood alterations.
- Tolerance is a normal adaptive response to opioids and is NOT addiction; as a result, one or more of the drug's effects may be reduced, and the dose may have to ne increased or decreased to produce maximum function and minimal side effects.

_____ I understand that a small number of patients may become addicted to opioid medication.

- If necessary, I will permit referral to an addiction specialist.

_____ I understand that the use of other medications can cause adverse effects or interfere with opioid therapy.

- I agree to notify my provider about all substances that I take, including over-the-counter and herbal remedies.

_____ I will not use any illegal controlled substances.

_____ I agree to cooperate with periodic unscheduled drug screens and understand that the presence of a nonprescribed or illicit drug in my urine can be grounds for treatment termination.

_____ I will take the medication at the dose and frequency prescribed.

- I will not increase the dose on my own.

_____ I will not seek opioid medication, other controlled substances, or anti-anxiety medications from another provider.

_____ I will not share, sell, or trade my opioid pain medication with anyone.

_____ I will safeguard my pain medicine from loss or theft.

- If my medication is stolen, I will report this to police and my provider and produce a police report of this event.

_____ I understand that lost or stolen medications **WILL NOT** be replaced.

_____ I understand that refills of my prescriptions will be provided only at an office visit or during regular office hours.

- No refills will be provided in the evening or on weekends.

_____ I will bring all unused pain and other medications to every office visit in the original bottles.

_____ I will use only _____ Pharmacy, located at _____,
telephone number _____, to fill prescriptions for all of my pain medicine.

_____ I agree that my pain management may be discussed with other health care professionals and my family members if deemed medically necessary in the provider's judgment.

_____ I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, in the investigation of any possible misuse, sale, or other diversion of my njhgypain medicine.

_____ I understand that if I break this agreement my provider will stop writing opioid prescriptions for me.

- In this case, my provider will taper the medicine over a period of several days, as necessary to avoid withdrawal symptoms and may recommend a drug dependence treatment program.

Patient Name (Please print.): _____

Patient Signature: _____ Date: _____

Witnessed By: _____ Date: _____

Physician Signature: _____ Date: _____

25805 Barton Road, Suite A106 Loma Linda, California 92354 (909)478-7777 Fax (909)478-3333