UNIVERSITY
HEALTH SERVICES
Tang Center

UHS Pain Management Agreement

Opioid (narcotic) treatment is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities. This many include exercise, use of non-narcotic analgesics, physical therapy, psychological counselling, or other treatments.

The purpose of this Agreement is to prevent misunderstandings about narcotic medications you will be taking for pain management. This is to help you and your clinician to comply with the law regarding controlled pharmaceuticals.

- I understand that this Agreement is essential to the trust and confidence necessary in a clinician/patient relationship and that my clinician undertakes to treat me based on this Agreement.
- I understand that if I break this Agreement, my clinician may stop prescribing these pain-control medicines.
- In this case, my clinician will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. A referral to an outside pain specialist or drug-dependence treatment program may be recommended.
- I will communicate fully with my clinician about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.
- I will not share, sell or trade my medication with anyone.
- I will not attempt to obtain any controlled medications, including narcotic pain medicines, controlled stimulants, or anti-anxiety medicines from any other clinician, barring a true emergency, or as communicated in advance to my clinician.
- I will not use illegal drugs and will also honestly inform my clinician of alcohol or other psychoactive substance use.
- I understand that I may be required to submit random urine samples for drug screening.
- I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate may result in my being without medication for a period of time.
- I will bring all unused pain medicine to every office visit.
- I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.
- I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.
- I agree to use _____ Pharmacy, tel_____, fax number _____, for filling prescriptions for all of my pain medicines.
- I authorize the clinician and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
- I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me. This document will be reviewed at least annually.

This Agreement is entered into on this _____ day of _____, _____.

Signed _____ _____
Patient Clinician

Reviewed _____ Signed _____ _____
Date Patient Clinician

Reviewed _____ Signed _____ _____
Date Patient Clinician