



# AGREEMENT FOR OPIOID MAINTENANCE FOR CHRONIC PAIN

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

PLEASE READ THE ENTIRE AGREEMENT. The purpose of this agreement is to give you information about the medications you will be taking for pain management, and to ensure that you and your provider comply with all state and federal regulations concerning the prescription of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of pain reduction and increasing functionality. The provider's goal is for you to have the best quality of life possible, given the reality of your clinical condition. The success of your treatment depends on mutual trust and honesty in the provider/patient relationship as well as full agreement and understanding of both the risks and benefits of using opiates to treat pain.

1. You must only use Corvallis Pain Management providers to prescribe and monitor all opioid medications and adjunctive analgesics.
2. You must use only one pharmacy to obtain all opioid prescriptions and adjunctive analgesics.

PHARMACY: \_\_\_\_\_ CITY: \_\_\_\_\_

3. You must inform your provider of all medications you are currently taking. This includes herbal remedies, over-the-counter medications, and other prescribed medications.
4. You will be seen on a regular basis and will be prescribed enough medication to last from appointment to appointment.
5. Prescriptions for any medication will be done only during regular office hours. No refills of medication will be issued during evenings, weekends, or procedure days.
6. It is our office policy to consider a medication taper or even a discharge if 3 or more appointments are missed (no-showed).
7. You must provide our office with a working phone number at which you can be reached AT ALL TIMES.
8. If you are leaving the area or state, for any reason, it is your responsibility to inform our office BEFORE you leave.
9. You are responsible for keeping your pain medication in a safe, secure place such as a locked cabinet or a safe. You are expected to protect your medications from loss or theft. Stolen and/or lost medications must be reported to the police and to your provider immediately. Medications will not be replaced by our office.
10. Selling or giving away your medications to any other person is not allowed under any circumstances. If you do, you may endanger your health and/or that person's health. It is also against the law.
11. It is at our providers' discretion to not provide you medication during your first office visit.
12. It is our clinic policy that opiates are prescribed on a less than 120 Morphine Equivalent Dose (MED) basis.
13. You must not use any illicit substances such as: cocaine, methamphetamine, heroin, ecstasy, or any other illicit substances. Alcohol and non-prescribed opiates and benzodiazepines are also NOT to be used. Marijuana, even if you have a valid medical marijuana card, is contraindicated and is not allowed. Use of this substance may result in a change to your treatment plan. Up to, and including, safe discontinuation of your opioid medications or complete termination of the provider/patient relationship.



# CORVALLIS

pain management

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14. You agree and understand that your provider reserves the right to perform random or unannounced drug testing. If requested, you agree to bring in all prescribed medications, in their original bottles, and provide a sample of urine, blood, or saliva within 24 hours. If you do not show up and/or decide not to provide a sample, you understand that your provider may change your treatment plan up to, and including, safe discontinuation of your opioid medications and/or complete termination of the provider/patient relationship.

15. If you have a history of alcohol or drug misuse/addiction, you must notify your provider of such history as treatment with opiates, for pain, may increase the possibility of a relapse. A history of addiction does not, in most instances, disqualify you from opioid treatment for pain; however, starting or maintaining a program for recovery is required. If prior abuse is noted, you must have documented sobriety for the last 6-12 months at the provider's discretion.

16. You agree to allow your provider to contact any health care professional, family member, pharmacy, or legal authority to obtain or provide information regarding your care or actions should the provider deem it to be necessary.

17. Any occurrence of drug hoarding, acquisition of any opioid medications from other providers (which includes emergency rooms), uncontrolled dose escalation or reduction, and loss of prescriptions is a violation of this agreement. This explicitly means that **you may not take more medication than is prescribed without consulting our office, use controlled medications that were not prescribed to you or were previously prescribed to you, or fill prescriptions from providers exterior to our office (including the ER) without consulting our office first.**

18. Additional information regarding the material risk notice, physical dependence, addiction, tolerance, and potential side effects is given on the following page.

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These regulations have been agreed upon by all providers in our practice. By signing this document, you agree to follow all rules and regulations set forth. Failure to follow this agreement in its entirety may result in tapering of the medication dose you are currently on and/or complete termination of the provider/patient relationship.

PATRICK RASK, MD

KASIA IWAN, MD

JAROD SMITH, NP

NANCY BURGESS, NP

JASON SMITH, PA

PATIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

WITNESS SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

Form created by the Oregon Medical Board for use by healthcare professionals to be retained as part of the patient's permanent medical record.

This will confirm that you, \_\_\_\_\_, have been **diagnosed** with the following condition(s) causing you chronic, intractable pain:

I have recommended treating your condition with the following **controlled substances**:

In addition to **significant reduction** in your pain, your personal **goals** from therapy are:

**Alternatives** to this therapy are:

Additional therapies that may be necessary to assist you in reaching your goals are:

**Notice of Risk: The use of controlled substances may be associated with certain risks such as, but not limited to:**

1. Central Nervous System: Sleepiness, decreased mental ability, and confusion. Avoid alcohol while taking these medications and use care when driving and operating machinery. Your ability to make decisions may be impaired.
2. Cardiovascular: Irregular heart rhythm from mild to severe.
3. Respiratory: Slowing of respiration and the possibility of inducing wheezing, causing difficulty in catching your breath or shortness of breath in susceptible individuals.
4. Gastrointestinal: Constipation is common and may be severe. Nausea and vomiting may occur as well.
5. Dermatological: Itching and rash.
6. Endocrine: Decreased testosterone (male) and other sex hormones (females); dysfunctional sexual activity.
7. Urinary: Urinary retention (difficulty urinating).
8. Pregnancy: Newborn may be dependent on opioids and suffer withdrawal symptoms after birth.
9. Drug Interactions with or altering the effect of other medications cannot be reliably predicted.
10. Tolerance: Increasing doses of drug may be needed over time to achieve the same pain relieving effect.
11. Physical dependence and withdrawal: Physical dependence develops within 3-4 weeks in most patients receiving daily doses of these drugs. If your medications are abruptly stopped, symptoms of withdrawal may occur. These include nausea, vomiting, sweating, generalized flu-like symptoms, abdominal cramps, abnormal heartbeats. All controlled substances need to be slowly tapered off under the direction of your physician.
12. Addiction (Abuse): This refers to abnormal behavior directed towards acquiring or using drugs in a non-medically supervised manner. Patients with a history of alcohol and/or drug abuse are at increased risk for developing addiction.
13. Allergic reactions: Are possible with any medication. This usually occurs early after initiation of the medication. Most side effects are transient and can be controlled by continued therapy or the use of other medications.
14. Accidental Overdose: In some instances, controlled substances may accumulate, leading to respiratory difficulty, coma, or death. This risk is increased by certain medical conditions, higher dose opioid treatment, other medications including tranquilizers, CNS depressants, alcohol, marijuana or other illicit drugs.

This confirms that we discussed and you understand the above. I asked you if you wanted a more detailed explanation of the proposed treatment, the alternatives and the material risks, and you (initial one):

\_\_\_\_\_ Are satisfied with the explanation and desired no further information.

\_\_\_\_\_ Requested and received, in sufficient detail, further explanation of treatment, alternatives, and material risks.

**PATIENT** signature: \_\_\_\_\_

Date: \_\_\_\_\_

Explained by me and signed in my presence.

**PROVIDER** signature: \_\_\_\_\_

Date: \_\_\_\_\_